MARYLAND	STATE DEP	ARTMENT	OF	HEALTH-	BALTIMORE,	18

			41	45	CER	TIFICA	ATE OF DEATH	Н		Reg. Dist	41	31	
1. PLACE (roll	- J. J.	***	M	ARYLAND	2. USUAL RESIDENCE (W. o. STATE Mary)		l lived. If institution b. COUNTY	on, Residence	e befor	o odmissi	ion)
RURA	OR TOWN (II At and give ne kesvil	orest town)	arate limit	, write	c. LENGTH OF ST		c. CITY OR TOWN (IF a		rote limits, write R	URAL and gi	ve nea	rest town	1
OR I	NE OF HOSPITA NSTITUTION Pingfi				oddress)		d. STREET ADDRESS None						FARM?
3. NAME : DECEAS (Type o	ED		Jaco	_	Snively		Adams	4. DATE OF DEATH	Apri		Day		Year 1959
s. sex Mal	.e	6. COLOR C		7. _{MARI}	RIED A NEVER MA	RRIED	Dec. 17, 188	39	9. AGE (In years lost birthdoy) 69 yrs.	Menths 1	YEAR		
during	nost of work	N (Give kind ing life, even	of work d if retired)	one 10b.	KIND OF BUSINES	OR INDU	TRY II. BIRTHPLACE (Slote Marylan)	_	ountry)		S.A		COUNTRY
13. FATHER Cha	rs NAME	dams					India No.		ford				
15. WAS D	mknown) i f	IN U. S. AR		ryscel	SOCIAL SECURITY I	-	pringfield Ho	ospita:	Records				
	PART I. DEAT	TH [Enter on TH WAS CAU IMMEDIATE	SED BY:		ne for (o), (b), and terioscle		heart diseas	se .			ONS	RVAL BE ET AND Cars	DEATH
Conc	ditions, if on the rise to in the (o), stating the course lost,	y, which	DUE TO (b). DUE TO	Ge	meralized	i arte	riosclerosis				Y	ears	
Bro	PART II. OTH mehopn	OULC I	eacu:	On			NOT RELATED TO THE TERM Consultation of the			EN IN PART	1(0) 15	PERFO	AUTOPSY RMED? NO 🔼
₹ 20c. TI	ME OF INJURY Hour o. m. p. m.	MEDICAL EXA	Day, Yea	20d. II While at wor	NJURY OCCURRED Not while k of work	20e. PL	ACE OF INJURY (Home, form tory, street, affice bldg., etc	20f, (City	or town)	(Co	ounty)		(State)
	certify the		ded the	deceas			a., 1959, toApp accurred at 12:10		19 <u>59</u>				

Coucks. M.D. Springfield Hospital

DATE SIGNED

Agustin del Campo, M.D.

Sykesville, Maryland

22c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery 22d. LOCATION (City, town, or county)
Williamsport

Maryland

240. REC'D BY REGISTRAR DATE APR 1 3 '59

24b. REGISTRAR'S SIGNATURE Circling & Kraus

7772 Sall table | age | middle miner The second secon The state of the s Mineral Tollege Male and Male Care de to the agent format of your fact County and the county and the The All Street S The state of the s In Dead of Marking the American bestern best transc Column ton mater was and surfacely grant than I have

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s 1 and 2	0/0	2
Post		

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

4146

04132 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Mary]	ere deceased lived. If institution b. COUNTY	n: Residence before odmission) Frederick
b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Sykesville	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If or	utside corporate limits, write RU	(RAL and give nearest town)
d. NAME OF HOSPITAL (If not in haspital, give street of National Springfield State Hospital		d. STREET ADDRESS RFD #1		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF First DECEASED (Type or print) John	Middle Lewis	Baker	4. DATE Monti	
5. SEX 6. COLOR OR RACE 7. MARR WIDOWE	ied Never Married Divorced Divorced	August 7, 187		IF UNDER 1 YEAR IF UNDER 24 HRS. Manths Days Haurs Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Laborer	Farm	ISTRY 11. BIRTHPLACE (Stole of Marylar		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME August Baker		14. MOTHER'S MAIDEN N		
	1 2/ 200/	INFORMANT pringfield Hos	pital Records	255
Conditions, if ony, which gave rise to immediate couse (a), stating the under-lying couse last.	rteriosclerot	ic heart disea		EN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES 7 NO 18
200. ACCIDENT WAS UNDERLYING 20b. DESC OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		ED. (Enter noture of injury in P	Port 1 or Part 11 of item 18.)	
Hour o.m. While	Not while k at work	LACE OF INJURY (Home, Farm, actory, street, affice bldg., etc.	20f. (City or town)	(County) (State)
21. I certify that I attended the decease alive on April 27, 195 ACTUAL SIGNATURE SHOWER SUBJECT STATES	ond that deat	h occurred at 7:43P M.D. Springfie:	M, from the causes one ADDRESS (Street, city or town, s Ld Hospital	that I lost saw the deceosed d on the dote stated above DATE SIGNED 14/28/59
PHYSICIAN'S Edmund Lusthaus			e, Maryland	
226. BURIAL, CREMATION, BURIAL Specify April 30,1959		thern Cem.		laryland
23. FUNERAL DIRECTOR'S SIGNATURE J Jaymond E. Gringer	ADDRESS Johnson	t golf DATE MI		TRAN'S SIGNATURE Withury & Krama

77.14 And the state of t Company the party of the contract of the Albert The second of the second secon or a first first teach Saltenia Catanitan the first that the same and the MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

e. IS RESIDENCE

Haurs

U. S. A.

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO

> > (Stote)

DATE SIGNED

1-16-59

(State)

Days

(County)

ON A FARM?

YES NO 1

Year

1959

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death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Reg. Dist. No.

18

IF UNDER 1 YEAR IF UNDER 24 HRS

Hours

Hancock. Md

ONSET AND DEATH

one hour

PERFORMED?

YES NO !

(Stote)

DATE SIGNED

Penna.

(County)

Cirthur S. Heraus

12. CITIZEN OF WHAT COUNTRY?

. IS RESIDENCE ON A FARM?

YES NO

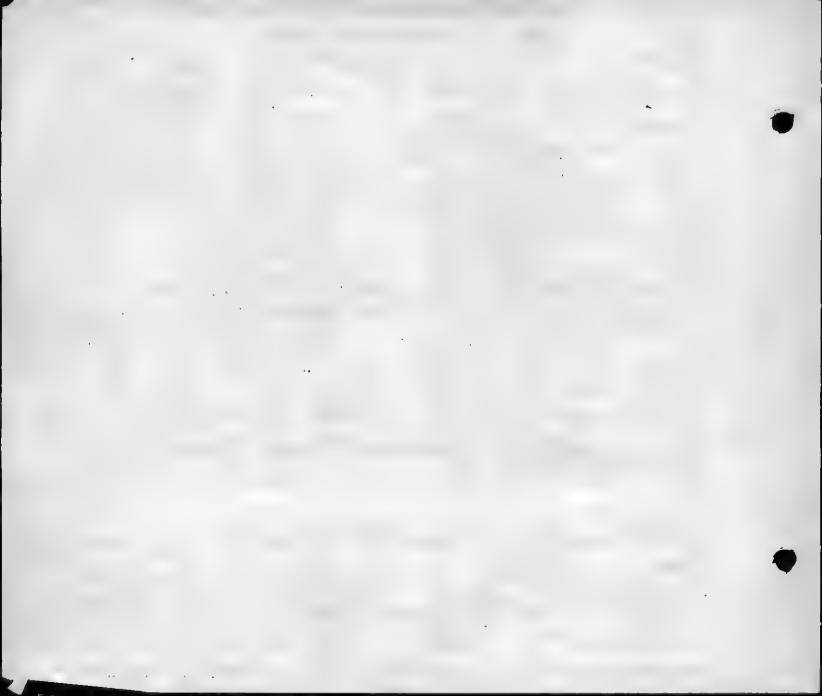
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1959

MARY AND STATE DEPARTMENT OF HEALTH-BALTMORE, LO. artimite PF and fatdicasi alete historiasi Market authorized 1111 . 50 105-* * * STREETS! The All of Man made and the transfer of the death manager to the second second The second state of the second second which the 10 createins called Appril Danes Strangwood et l

4150 **CERTIFICATE OF DEATH** Rea. Dist. No With. 1. PLACE OF DEATH 2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admissionil o. COUNTY filed ! b. COUNT MARYLAND 4 b. CITY OR FOWN I'll outside corporate limits, write E-LENGTH OF STAY IN 16 c. CITY OR TOWN (If-objside corporale limits/verite RURAL and give nearest town) BURAL and give nearest town d. NAME OF HOSPITAL (If not in hospital, give street/oddress d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON'A FARM? YES TO NO T NAME OF fini DATE Month Year DECEASED (Type/or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTHY AGE (In years less, birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours WIDOWED | DIVORCED T 100, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign during most of working life even if retired) 12. CITIZEN OF WHAT COUNTRY? carbon 13 FATHER'S NAME 4. MOTHER'S MAIDEN NAME MOVE IS, WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 134 INFORMANT Address CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL SETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY all-property IMMEDIATE CAUSE (o) 10 4-20,1 **DUE TO** Conditions, if eny, which] gove rise to immediate **DUE TO** couse (a), stating the underlying couse lost. PART III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS PERFORMED? YES NO 🗔 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c, TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a. ft. While Not while of work of work p. m. 21. I certify that I attended the deceased from For 19 to to to the second 2.2., 19.5.4., that I last saw the deceased ____, and that death accurred at 5 25 2M, from the causes and an the date stated above ADDRESS (Street, city or town, stole) DATE SIGNED ACTUAL SIGNATURE TO FUNERAL DIR page 3 should t PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION 225. DATE THEREOF AC NAME OF CEMETERY OR CREMATORT 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b. REGISTRAR'S SIGNATURE 24a. REC'D/BY REGISTRAR APR 2 8 '59 arthur & Thousa

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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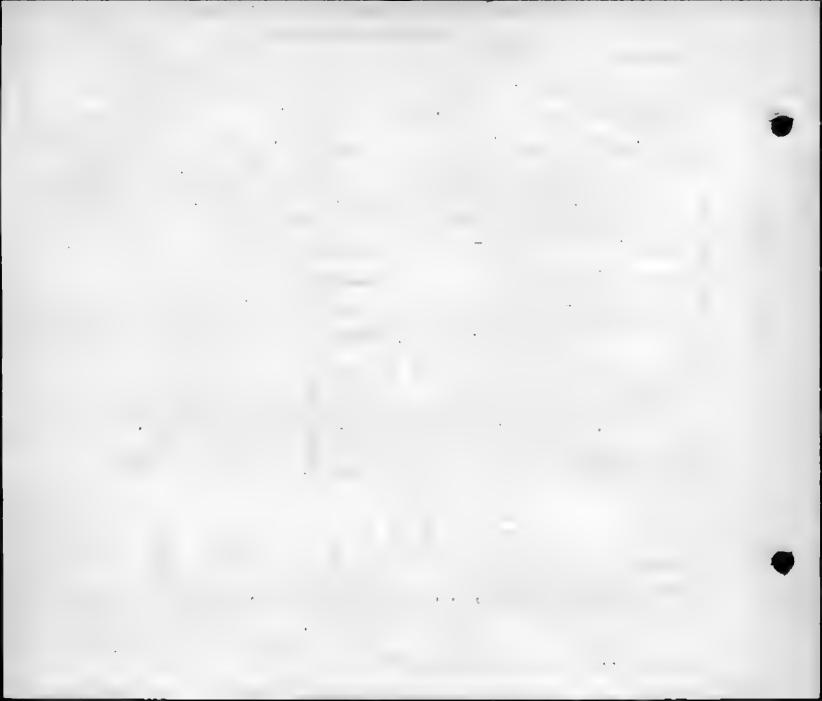
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MARYLAND	STATE	DEPARTMENT	OF	HEALTH-BALTI	MORE.	18
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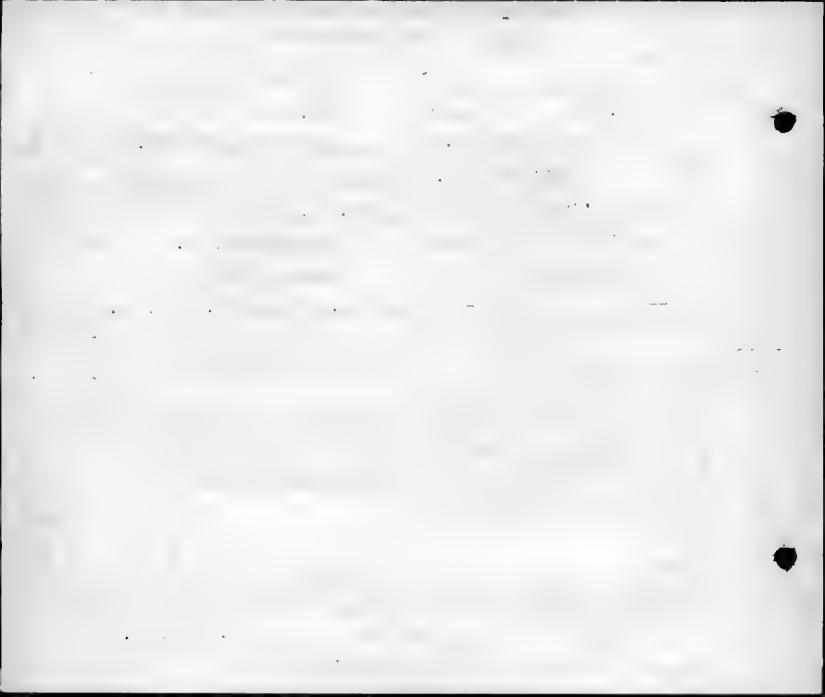
CERTIFICATE OF DEATH

04137

L			415	CLI	(11110)	TIL O	DEAL	11		Reg. D	ist. No.		
1	PLACE OF DEATH a. COUNTY					2 USUAL	RESIDENCE (W	here decease	d lived. If institu		nce befor	e admis	sion)
	Carroll				MARYLAND	o STA	arvland		b. COUNT	Y OH:	tr		
Г		outside corporate limi	ts, write	c. LENGTH OF	STAY IN 1b			outside corpo	role limits, write			rest fow	n)
	_Svkesvil			1 mo.	20 day	B B	ltimore	9	197	V - 1	,		
_		AL (If not in hospital, g	ive street			7?	EET ADDRESS				- 7.7	e. IS RES	SIDENCE
L		eld State I	Hospi	tal		6	Il Ensor	r Stree	et				NO P
3.	NAME OF DECEASED	Fir	st.	м	liddle		Lost	4. DATE OF	М	onth	Do	y	Year
L	(Type or print)	John			MN	C	SCIO	DEATH	April		15		19 59
5.	SEX	6. COLOR OR RACE	7. MARE	IED 🔲 NEVER M	ARRIED 🙀	B. DATE OF	BIRTH		9. AGE (In year last birthday)		-	-	ER 24 HRS.
L	Male	White	WIDOWI	DIV	ORCED 🔲	9/4/	38		70 Y		Days	Hours	Min,
10	 USUAL OCCUPATION during most of work 	N (Give kind of work ing life, even if retired	done 10b.	KIND OF BUSINE	ESS OR INDU	STRY 11, BI	RTHPLACE (Stote	e or foreign c	ountry)	12. CI	TIZEN O	F WHAT	COUNTRY?
L	Laborer			-			talv			A	lien	(?)	
13	FATHER'S NAME					14. MOT	HER'S MAIDEN	NAME					
L	Paul Ces	nio				A	ngela D	entico					
15	WAS DECEASED EVER	IN U.S. ARMED FOR	CE\$? 16.	SOCIAL SECURIT	Y NO. 17. I	NFORMANT	-6		Ac	dress			
Ľ	no					Sprin	field !	Hospit	al Recor	ds			
Г	18 CAUSE OF DEA	TH [Enter only one co	use per fit	ne for (o), (b) and							INTE	RVAL BI	TWEEN
		TH WAS CAUSED BY:		reinoma	_	stons	ch				ONS	et and	DEATH
	151x	DUE TO			<u> </u>	D O O DIAC	V44						***
	Conditions, if ar	y, which) (b											
	gave rise to in	mediate (-								
	lying couse lost.	ne <u>under-</u>	4										
Z	PART II OTH	ER SIGNIFICANT CON	DITIONS	ONTRIBUTING TO	DEATH BUT	NOT RELAT	ED TO THE TERM	INAL DISEAS	E CONDITION G	VEN IN PA	RT 1(o) 15	P. WAS	AUTOPSY
CERTIFICATION	CBS asso	c. with cer	rebra	I arteri	oscler	osis,	with p	sychot:	ic react	ion.		PERFC	NO T
ĬĔ	20a. ACCIDENT WA	S UNDERLYING []	20b DES	CRIBE HOW INJU	RY OCCURRE	D. (Enter no	ure of injury in	Port I or Par	t It of item 18)				- LAL
l H	(IF EITHER, NOTIFY	S UNDERLYING () () CAUSE OF DEATH MEDICAL EXAMINER)											
13	20c. TIME OF INJUR	Month, Doy, Yes	or 20d II	NJURY OCCURRED	20a. PL	ACE OF INJ	JRY (Home, for	m, 20f. [City	or town)		(County)		(State)
MEDICAL	Hour o.m.	19	While of wor	Not while	T Fo	ctary, street,	office bldg , et	c.)			,,		,
3					la sous a sou	. 25	50 · A		5	<u> </u>			
		at I attended the											
	alive an_Apr	1115	, 12	59, and	that death	accurre	1 ot 1912				the dat		
	ACTUAL	The state of	_//	10 /2	mpo.				treet, city or town			1/25	ATE SIGNED
	SIGNATURE	Grocevi	æ	<u> </u>	Topo.	M.D	inringi	ie la S	tate Hos	pical		4/12	7.27
	PHYSICIAN'S NAME (Type) A	pustin del	Camr	o. M.D.	/		Sykesvi	lle, M	aryland				
22	. BURIAL, CREMATIO	V. 225. DATE THEREC)F	22c NAME OF	CEMETERY O	R CREMATO	RX.	22d LQCA	TION (City, fown	or county)	,	(Sto)	 e }
	Burial	4/18/5	9	Holy	Redee	emer (em.	Ba	ltimor	e, Mo	rryl	and	
23	FUNERAL DIRECTOR'S			ADDRESS			24a. REC	D BY REGIST	RAR 24b. REC	SISTRAR'S &	GNATUR	E	
1	eonard S	. Ruck 5	305	Hartore	d Koad	2 #14	DATE	R 2 0 '5	9 6	ritur L	/ Stall	•	

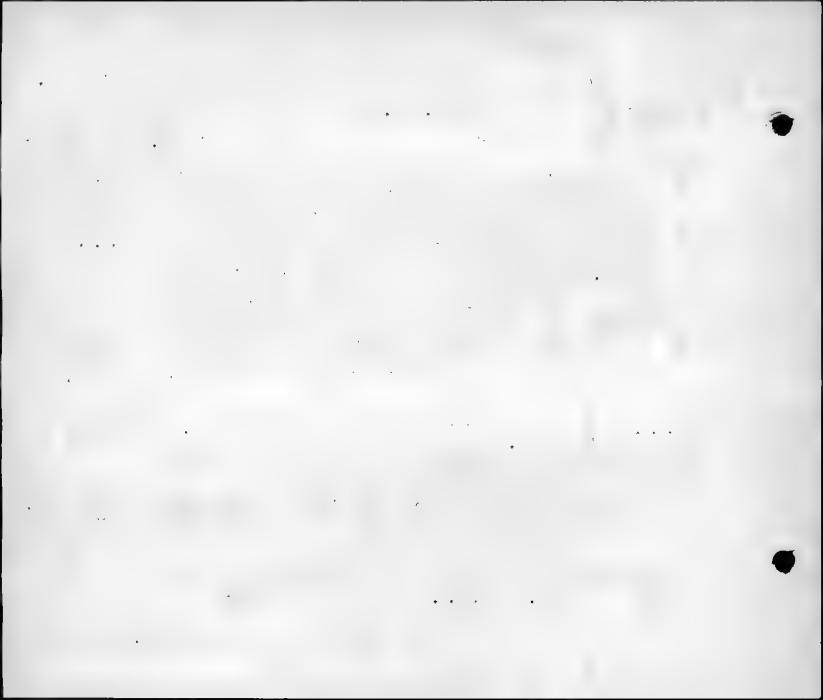


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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Rea. Dist No. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY **b** COUNTY Carroll Baltimore Co. Marvland MARYLAND b. CITY OR TOWN (II outside corporate limits, we to RURAL C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29yrs.6mos.3days Baltimore 24 Sykesvilla d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDE ALE ON A FARMA Springfield State Hospital 306 North Point Rd. YES NO P 3. NAME OF Middle Month DECEASED Daisy Crafton [Type or print] April 30. DEATH 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 2 8 DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS Months Moura Female White WIDOWED | DIVORCED T 2 hour 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? U.S.A. Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Dudley J. Crafton Barbara Frank 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: Bronchial pneumonia IMMEDIATE CAUSE (o) Dave DUE TO Conditions, if ony, which Hemorrhages right lung due to fractured ribs gove rise to immediate cause **DUE TO** (o), sloting the underlying cause last. PAN H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED? Parkinson's Disease. NO! 20o. EXTERNAL CAUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of Hem 18.) PRIMARY () or CONTRIBUTING Unknown Month, Doy, Year 20d, INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 120f. (City or town) (County) (Stote) factory, street, office bldg, etc.) While Not while at work of work Hospital Sykesville Carroll Md_ 21. I certify that I taok charge of the remains described above, held an Autopsy 📆 Inspection 🔣, Inquiry 3 CTOR opinian degith resulted fram: Natural causes . Accident 🔼 Suicide . Homicide . Undetermined manner DATE SIGNED **ACTUAL** CHIEF MEDICAL EXAMINER SIGNATURE should be FUNERAL I EXAMINED'S James T. Marsh. M.D. DEPUTY MEDICAL EXAMINER 174 NAME Dype) 220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, lown, or county) [State] REMOVAL (Specify) 0 Burial Oak Lawn Cemeterv TOPE Co., Maryland 23. FUNERAL DIRECTOR'S SIGNATURE 24g. REC'D BY REGISTRAR **V5. A15ME** Dundalk Cirthun S. Krous SAA 2757



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4155

CERTIFICATE OF DEATH

Reg. Dist. No.

,			3200		OEKIII I O	AIL U		•		Reg. Dis	t. No.	1/4-4	
	1.	LACE OF DEATH				2 USUAL o STAT	RESIDENCE (WI	here decease	d lived If institution	ani Residenc	e before	e admiss	ion)
	79.	Can	rroll		MARYLAND	d SIAI	Mary	land	b. COUNTY	Bal	to.C	itv	
ð.	t	CITY OR TOWN (If outside corporate limits, v	vrite	c. LENGTH OF STAY IN 16	P1			orale limits, write R				1)
		Sykesvill	le.		29yrs,2mos,]	.∄days	Balt	imore		31.	37 -	6 pa	
-		OF INSTITUTION	AL (If not in hospital, give	street o	oddress)	11	EET ADDRESS				•	. IS RES	FARM?
À		Springfie	eld State Hos	pit	al	2	500 Rei	sterst	own Rd.				NO 🍱
		NAME OF DECEASED	First		Middle		Lost	4. DATE	Mon		Day		Year
		(Type or print)	Frank		James	Croo	k	DEATH	Apri.	L	19,		1959
	5. 5			MARR	IED NEVER MARRIED	B. DATE OF			9. AGE (In years lost birthday)	IF UNDER			
	_	Male	White w	DOWE	DIYORCED	July	12, 18	97	61 yrs	MONTHS	Days	Hours	Min.
	100.	. USUAL OCCUPATION during most of world	ON (Give kind of work done king life, even if retired)	106	KIND OF BUSINESS OR IND	USTRY 11 BII	THPLACE (State	or foreign c	country)	12. CIT	ZEN OF	WHAT	COUNTR
		Attendar	nt e	<u> </u>	-		Marylan	d			U.S	.A.	
	13.	FATHER'S NAME				14 MOTI	HER'S MAIDEN	NAME					
		James W.				M	ary E.	Quinn					
	15. Yes	, no or unknown))	R IN U. S. ARMED FORCES:		SOCIAL SECURITY NO 17.	INFORMANT			Addr	esi.			
		No	-		-	Spring	field H	ospita	1 Records	3.			
			ATH [Enter only one cause	•							INTER	RVAL BE	TWEEN
		PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (0)	Cer	ebral thrombo	sis						ours	
		332 X	DUE TO	_		_							
		Conditions, if a		Cer	ebral arterio	sclero	s is				Y	ears	}
		gove rise to i couse (o), stating	> DHE TO	Com	eralized arte	wi enel					T.		
	_	lying couse lost.										ears	
	ğ	Schizopha	ter significant conditi	ONS C	hebephrenic t	IT NOT RELATI	D TO THE TERM	INAL DISEAS	E CONDITION GIV	EN IN PART		PERFO	AUTOPSY PMED?
)	Ϋ́											YES 🗌	NO 🚰
,	CERTIFICATION	OR CONTRIBUTING	AS UNDERLYING [] 206 CAUSE OF DEATH MEDICAL EXAMINER!	. DESC	TRIBE HOW INJURY OCCURR	ED (Enter nat	ure of injury in	Port 1 or Por	t II of item 18)				
		20c. TIME OF INJUR		204 15	JURY OCCURRED 20e F	NACE OF INIII	JRY (Home, farm	- 100t (Cit.					451.1.1
	MEDICAL	Hour o. m.	,	While	Nat while	octory, street,	office bldg , etc	ii, †201. (Cii) ii) ¦	y or lawnj	(C	ounly)		{Stale}
	2	p. m		_	af work			-13 30					
				cease	d from March 7,								
		alive on Api	11 179	12.2	2, and that deal	h accurred			m the causes a treet, city or lown, i		ie date		ed abav ATE SIGNE
		ACTUAL	mentain a	90	P Campo	C.					1	1. /00	/CQ
,		SIGNATUTE	gurevivi 9			_M.D	<u>OLTURIT</u>	era 20	ate Hospi	TAT.		1/29	177.
Į.		PHYSICIAN'S NAME (Type)	Agustin delC	amp	o. M.D.	S	ykesv i l	lek Ma	ryland				
	220		N, 226. DATE THEREOF	-	22c. NAME OF CEMETERY				TION (City, town, o	County)	*****	(State	•)
		REMOVAL (Specify)				stine		1	4.5	Mary!	land		e)
		FUNERAL DIRECTOR			ADDRESS	- OTILCI		D BY REGIS		TRAR'S SIG		_	
	H	loward H.	Hubbard 4	10	7 Wilkens A	venue		PR 2 2		thur L	House	4	

TO FUNERAL DISCOUNTED THE Maspital or attending physician.

TO FUNERAL DISCOUNTED THE Maspital or attending physician.

TO FUNERAL DISCOUNTED THE Mass certificate has been signed by the attending physician and completely filled in by filled with page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or remarks on any event within 72 hours after death. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4 TO HOSPITAL OR

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VS A15 (4) 15M 9/55

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TO HOSPITAL OR

VS A15 (4) 1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4141

CERTIFICATE OF DEATH

04142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
MARYLAND MARYLAND	a. STATE b. COUNTY A A A A A A
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)
17 minutes 12 mon	14/12 to diente
d. NAME OF HOSPITAL (If not in haspital, give street address)	d. STREET ADDRESS e. 15 RESIDENCE ON A FARM?
OR INSTITUTION	1 1/ 1/ 10 d / 1/2 YES NO T-
3. NAME OF DECEASED (Type or print) / 1/24/Hirl HERBERT	- CRCh2 L DATE Month Day Year OF DEATH MANTH 19.
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	B. DATE OF BIRTH 9. AGE In years IF UNDER 1 YEAR IF UNDER 24 HRS.
MALL WIDOWED DIVORCED	Manths Days Hours Min.
100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU: during most of working life, even if retired)	STRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY
Lies and die De Care	the said that will test it is in
13 FATHER'S NAME	14. MOTHER'S MAIDEN NAME
27-c11 "1 Oh D	D. B. 1.7
LONGA VINTAL	in 130 A 1 Tilken of
the second of th	NFORMART 4 Address 4
(11 yes, give wer or detes of service) 220-26-60012	De H Coset love to the 1
1B. CAUSE OF DEATH [Enter only one cause peryline for (a), (b), and (c).],	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY:	Cellar Raya Ochisanse Woult-19:55
IMMEDIATE CAUSE (a)	
+400 DUE TO CEREBULET	Theoretiases
Canditians, if any, which gave rise to immediate (b)	Steenes (County 1 og us
case (a), stating the under-	
lying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY
Ř	PERFORMED?
200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED	D. (Enter nature of injury in Part t or Part II of item 18.)
OR CONTRIBUTING LI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	S. (Chief Halors of Impory in Part Col. Part II of Helle 16.)
	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
Hour a.m. Yhile Not while for at work of work	ctory, street, office bldg., etc.)
Is a site	10 CT 6 41 : 0 10 - N.
21. I certify that I attended the deceased fram ISON 1.7	, 1955, ta applied 0, 1957, that I last saw the deceased
alive an left see 1957, and that death	occurred at 30,5 M, from the causes and an the date stated above
11260 ~ 1	ADDRESS (Street, city or town, state) DATE SIGNED
SIGNATURE WILLIAM TREEKEN	MD Westurister Hus Grafil-193
NAME (Type)	
220. BURIAL, CREMATION, 22b, DATE THEREOF 22c. NAME OF CEMETERY O	R CREMATORY 22d. LOCATION (City, town, or county) [State]
TREMOVAL (Specify)	and it will a policy the said
23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	c. The m Marina Reserving 11 1 1/24 1
ADDRESS ADDRESS	26. AEGISTRAR 246. REGISTRAR'S SIGNATURE
A 11. 1. 1. 1 1 1. 7 31/1. 11. 15 121	DATE DATE



please remove

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No

M)	1. PLACE OF DEATH COUNTY Garroll

4356

Henryton

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) MARYLAND

c. LENGTH OF STAY IN 16

Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Raltimore d STREET ADDRESS

Months

. IS RESIDENCE ON A FARM? YES NO

Yaor

Henryton State Hospital NAME OF DECEASED (Type or print) Charles

RURAL and give nearest town)

b. CITY OR TOWN (If outside corporate limits, write

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Davis, Jr.

4. DATE DEATH

Galesville, Maryland

603 Collett Street

April 9. AGE (In years ast birthday)

Month

b. COUNTY

19 IF UNDER I YEAR IF UNDER 24 HRS

5. SEX Male 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Negro WIDOWED Seppivorced

Nov. 10. 1910 100 USUAL OCCUPATION (Give kind of work done 105, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) during most of working life, even if retired)

12. CITIZEN OF WHAT COUNTRY? U. S. A.

Days

Unknown 13 FATHER'S NAME

14. MOTHER'S MAIDEN NAME Unknown

INTERVAL BETWEEN ONSET AND DEATH

Charles Davis, Sr. 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO

2 days

Middle

17. INFORMANT

Address

PART I DEATH WAS CAUSED BY

Unknown

Charles Davis, Jr.

B. DATE OF BIRTH

No

lying couse lost.

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

Cardiac insufficiency

Far advanced bilateral extensive pulmonary TB

Conditions, if any, which gove rise to immediate couse (a), stating the under-

IMMEDIATE CAUSE (o)

DUE TO

with bileteral cavitation

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Port II of Item 18.)

PERFORMED? YES NO

200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c, TIME OF INJURY Month. Hour o. m.

20d. INJURY OCCURRED Not while

20e. PLACE OF INJURY (Home, form, 20f. (City or town) factory, street, office bldg., etc.)

[County]

(Stote)

of work of work

21. I certify that I attended the deceased from April 2. . . 1959, to April 3. . . 1959, that I lost saw the deceased

___, and that death accurred at 6:15 PM, from the causes and on the date stated above. DATE SIGNED

ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type)

Dr. Edgars M. Maculans, Supt. 22b. DATE THEREOF

Henryton State Hospital.

Henryton, Maryland

ADDRESS (Street, city or town, state)

PURIAL CREMATION. REMOVAL (Specify)

246. REC'D BY REGISTRAR

AAR 1 3 '59

24b. REGISTRAR'S SIGNATURE arthur & Kraya

23 FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

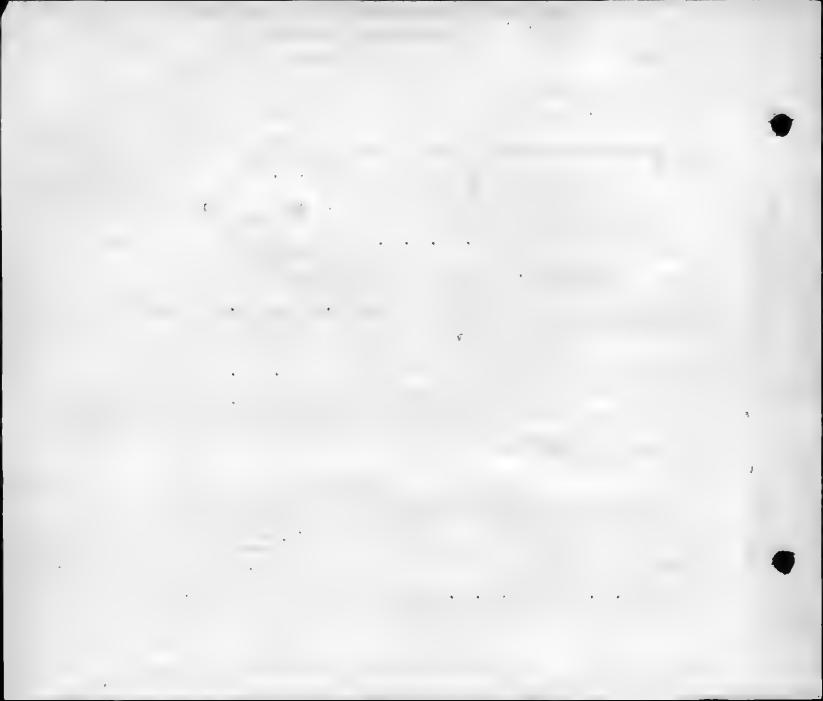
0 15M 9/55

FUNERAL D



CERTIFICATE OF DEATH Rea, Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived If institutions Residence before admission) g. COUNTY **b. COUNTY** be-Filed MARYLAND 4 Carroll Marvland Allegany b. CITY OR TOWN (If autside carparate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest lown) Henryton, Maryland 154 days Cumberland d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE 329 Frederick Street Henryton State Hospital YES | NO K NAME OF DECEASED John Davis Sr. Henry April DEATH 19 59 (Type or print) 6 COLOR OR RACE 7. MARRIED TO NEVER MARRIED 9. AGE (In years last birthday) 5. SEX 8 DATE OF BIRTH IFUNDER I YEAR IF UNDER 24 HRS Manthu Days Negro Male WIDOWED | DIVORCED | 2-1-1899 10a. USUAL OCCUPATION [Give kind of work dane 10b KIND OF BUSINESS OR INDUSTRY 11, SIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) West. Md. R. R. Laborer Cumberland, Maryland USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William R. Davis Susan Bates 15, WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address John H. Davis. Sr. - Patient No 705-10-4953 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio Vascular insufficiency DUE TO Far advanced bilateral pulm. toc. c cavitation Conditions, if any, which] gave size to immediate **新光 张米** cause (a), stating the under-Thrombophlebitis of the left leg. lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES NO [7 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, Doy, Year 20d. INJURY OCCURRED 20f. (City or town) (State) (County) factory, street, affice bldg., etc.) Hour o. m. Not while at wark at wark 21. I certify that I attended the deceased from November 5, 19 58, to April 8, 19 59that I last saw the deceased olive on April 19.59 and that death accurred at 12:45 p.M. from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL Henryton, Maryland PHYSICIAN'S E. M. Maculans, M. D. Henryton State Hospital 220. BURIAL, CREMATION. 22c NAME OF CEMETERY OR CREMATORY (Stole) REMOVAL (Specify) ADDRESS 23. FUNERAL DIRECTOR'S SIGNATURE 24g REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Chilling & House

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04145 CERTIFICATE OF DEATH 4142 Rea. Dist. No. with director, PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) filed, o. COUNTY COUNTY MARYLAND CITY OR TOWN (If outside corporate limits, write C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give neares) town) è RURAL and give nearest town). 000 d. NAME OF HOSPITAL (If not in hospital, give street address) A STREET ADDRESS e. IS RESIDENCE ON A FARM? 25 YES TO NO PA Ξ NAME OF First Middle 4. DATE Month Doy Year filled DECEASED OF (Type or print) 19 6 5. SEY 6. COLOR OR RACE MARRIED NEVER MARRIED 2 8. DATE OF BIRTH 9. AGE (In years IF LINDER AYEAR IF LINDER 24 MES lost birthday) Months Doys Hours Min WIDOWED T DIVORCED [7] 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (Stole or 12. CITIZEN OF WHAT COUNTRY? and 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT (Yes. no. or unknown) (If yes, give war or dates of service) aftending 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1 4/05 DUE TO ģ 20X Conditions, if ony, which gove rise to immediate DUE TO cosse (o), stating the underlying couse lost. burial-transit (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY CATION PERFORMED? YES | NO | 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Part II of item 18.) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (County) (Stote) factory, street, office bldg., etc.) Hour o.m. While Not while at work of work p. m. 21. I certify that I attended the deceased from APP1/25 1950 to APRIL 30, 1959 that I last saw the deceased detached , and that death accurred at 9:30 AM, from the causes and an the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED ACTUAL prior å. DIRE should PHYSICIAN'S TO FUNERAL NAME (Type) ന 22b. DATE THEREOF BURIAL CREMATION, 22c. NAME OF CEMETERY OF CREMATORY 22d. LOCATION (City, town, or county) (Stote) page 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 240/ REC'D BY REGISTRAR 44b. REGISTR

Page

deoth.

HOSPITAL

VS A1S (4) 15M 9/5S

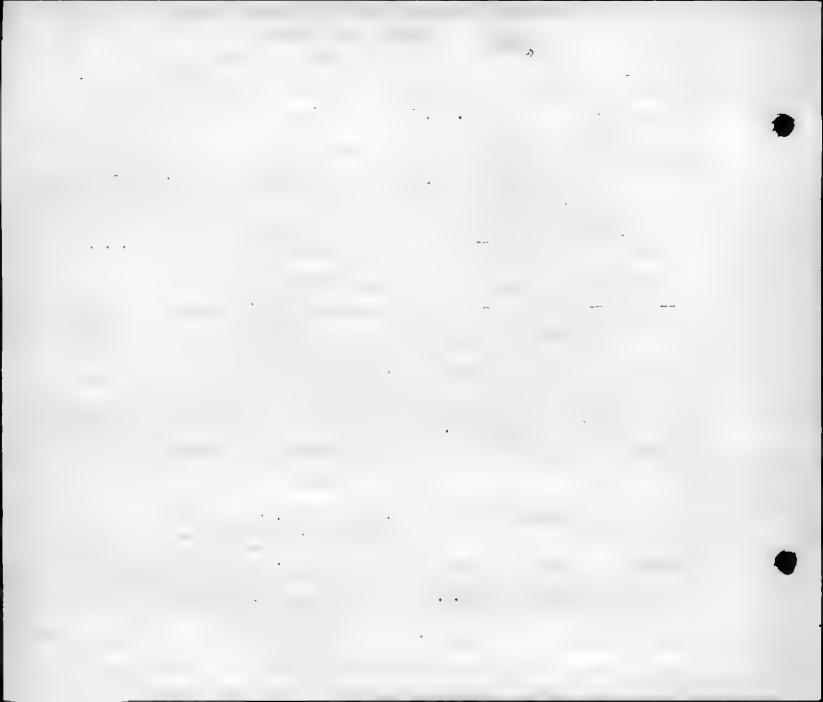


MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH 4158

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1.	PLACE OF DEATH		*-		ALA BVI	4440	2	JSUAL RESIDENCE (W	here decease	d lived If institut	ioni Resid	ience befa	re odmisi	lion)	
	Carroll				MARYL	AND.		Maryland				more	C4++	T	
Г	b. CITY OR TOWN (I RURAL and give no	f outside corporate limi arest town)	ls, write	c. LENG	TH OF STAY I	ИЪ	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)								
	Sykesvil	le		75v.	9mo. 21	dava	Baltimore CVc/4								
Г	d. NAME OF HOSPIT	AL (If not in hospital, g	ive street	oddress)				d. STREET ADDRESS					e. IS RES	IDENCE	
L	OR INSTITUTION	eld State H	Ineni	tell										FARM?	
<u> </u>		BIG OFACE I	10901	. Va L			<u> </u>						165] NO []	
3.	NAME OF DECEASED	Fir	st e		Middle			Last	4. DATE	Mo	nth	Do	у	Year	
	(Type or print)	Leonor	1		G.		10	verhart.	DEATH	Apr	47	73		19 Kg	
5.	SEX	6. COLOR OR RACE		N KA USIG				TE OF BIRTH		9. AGE (In year		ER I YEAR			
	Female									lost birthdoy)	Month		Hours	Min.	
ᆫ	Female	White	WIDOW		DIVORCED	_		<u>Unknown</u>		65 yri					
100	USUAL OCCUPATION	N (Give kind of work ing life, even if retired	done 10b.	KIND OF	BUSINESS OF	CINDUS	TRY	11 BIRTHPLACE (Stote	or foreign c	ounlry]	12,	CITIZEN C	F WHAT	COUNTRY	
ı	Housewif	ing tre, even ir rettrec	'					Unknown				TT C I			
13	FATHER'S NAME	9						MOTHER'S MAIDEN I				U.S.A			
'"	TATILLY STANKE						1	WO LUCK 2 WINDER	INAME						
L	Unknown							Unknesm.							
		R IN U. S. ARMED FOR		SOCIAL S	ECURITY NO	17. IN	VFOR	MANT		Ad	dress				
1"	i. no or unknown)	lif yes, give wor or dates of s	ervice)												
H						1 3	1014	ingfield H	ospila	TRECORD	3				
)	TH [Enter only one co	use per li	ne for (o),	(b), and (c).]								ERVAL BE		
	PART ! DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (6)	Sh	lock (due to	tra	uma	2					ours		
L	L""	OUE TO		**									<u> </u>		
				_	_										
	Conditions, if or gove rise to it)Pr	olani	se of r	ect	um								
	couse (a), stating		1									- 1			
	lying couse lost.	lc lc	1												
z	PART II OTH	ER SIGNIFICANT CON	DITIONS (CONTRIBU	TING TO DEA	TH BUT	NOT	RELATED TO THE TERM	INAL DISEAS	E CONDITION GI	VFN IN P	APT Mos 1	9 WAS	AUTOPSY	
팀	Schizoph	renia, par	anoid	typ	e .			THE PERSON NAMED IN COLUMN	mine biskus	2 (0,12,1,0,1,0,1	*******	- 101	PERFO	RMED?	
Ιō													YES 🗌	NO 📆	
CERTIFICATION	20g. ACCIDENT WA	S UNDERLYING CAUSE OF DEATH	206. DES	CRIBE HO	W INJURY OC	CURRED	(En	ter noture of injury in	Port I or Pari	t II of item 18.)					
Ü	(IF EITHER, NOTIFY	MEDICAL EXAMINER)													
₹	20c. TIME OF INJUR	Y Month, Day, Yes	or 20d ii	NJURY OC	CURREN	20e PLA	CEC	F INJURY IHome, form	20£ (City	or town)		(County)		(State)	
MEDICAL	Hour o.m.		While	Not	while	foci	lory,	street, office bldg., etc	:.)	or town;		(County)		farers	
Ĭ	p.m.	19	of wor	k 🔲 of w	ork 🔲				j						
	21 L certify th	at I attended the	decens	ed from	Octob	יי מי	20	105)1 to Az	nn17 1	3 10 E	Q that	Llaster	nu tho	docoored	
L	alive an Apr	47 72	30 5												
	dive an ADA	**		Z	and that o	death	acc	urred at 7:20.	_DM, fran	n the couses	and an	the da			
	5	1 1.	P	-4					ADDRESS (SI	lreel, city or town	, slole)		DA	ATE SIGNED	
	SIGNATURE C	bunce of 5	XLL	-s 64	an	- A	u b	Springfi	eld S	tate Hos	nita'	1 1.	/11./	CO.	
									Pilled while or help .		Part Met.		/- 	تر غر	
L	PHYSICIAN'S NAME (Type)	Edmund Lus	thau	ıs, M	D.			. Sykesvi	Lle, M	aryland					
220	REMOVAL (Specify)	N. 236. DATE THEREC	F	325 NA	ME OF CEME	TERY OR	R-CRE	MATORY 2	298 LOCA	JON (City lown)	or county	1	(Stol	e) ,	
1		Mary 161	1959	1/1/1	67 M.C	in	2/2	nylbans	1	Sall	no	MP.	W	el.	
23.	FUNERAL DIRECTOR	SIGNATURE	1.1	MOT	DRESS	71/7		240. REC'	D BY REGIST	RAR 246 REG	ISTRAR'S	SIGNATU	RE		
ā	Touch	1 Ma	ollis	1/11	Par Vi	1/0	n p	Xee / X			1 0	20			
Ľ	()	T. / WIMM	1//	1/14	will	PB		DATAP	121 '59	Clu	trust of	Thatte	~~~		

VS A15 (4) 15M II/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

death.

requires that the death certificate

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permit.

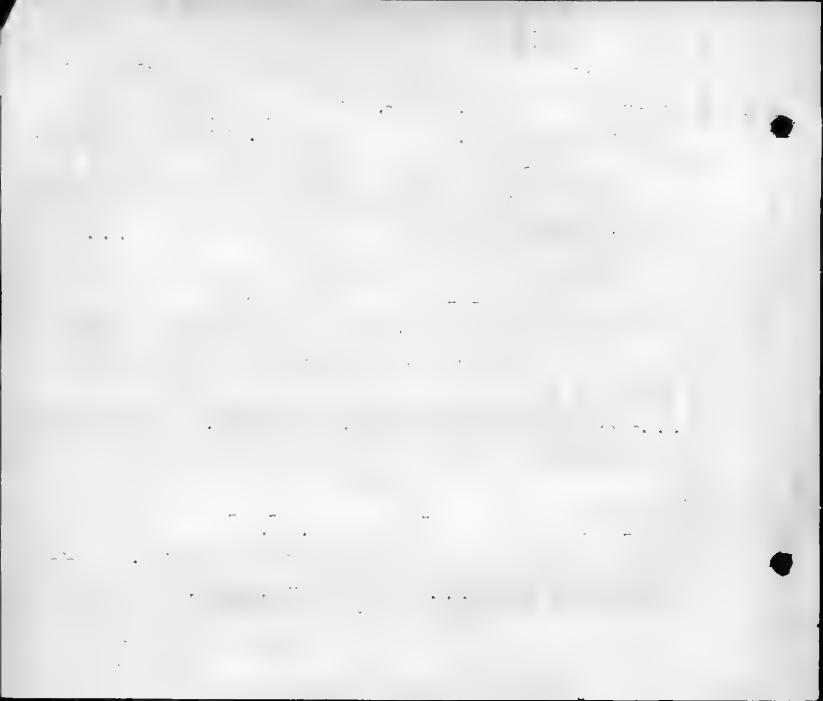
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signed



V5 A15 (4) 15M 9/55

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V

MARYLAND	STATE DEPARTMENT	OF	HEALTH-BALTIMORE,	18
4160	CERTIFICATE	OF	DEATH	

M

04148

								Keg. Dit	1, 140,		
1. PLACE OF DEATH 0. COUNTY				51	P. USUAL RESIDENCE (Where deceo	sed lived If instituti		e before	odmissi	onj
Carroll			MARYLA	ND	Maryland		B COUNTY	Alleg	any		
b. CITY OR TOWN (If RURAL and give no	outside corporate limi	its, write	c LENGTH OF STAY IN	1Ь	c. CITY OF TOWN (I	f outside corp	porote limits, write f	RURAL ond g	ive hear	est fown	
Svkesvil:	Le		9 mos. 17	lays	Cumber la	nd		1.	*		
d. NAME OF HOSPITA	AL (If not in hospital, g	jive street	oddress)		d. STREET ADDRESS					. IS RESI	DENCE
	old State				216 Pied	mont A	venue			YES 🗍	
3. NAME OF DECEASED	Fir	rst	Middle		Lost	4. DATE	Mor	nth	Day	Y	eor
(Type or print)	Marie		Goldie]	FOGIE	DEAT	H April	L	8	1	9 59
5. \$EX	6. COLOR OR RACE	7. MARS	RIED T NEVER MARRIED		DATE OF BIRTH		9. AGE (In years	IF UNDER		F UNDE	R 24 HRS
Female	white	WIDOWI	ED DIVORCED		6/12/96		last birthdoy) 62 yrs.	Months	Doys	Hours	Min.
10a. USUAL OCCUPATIO	N (G ve kind of working life, even if retired	done 10b.	KIND OF BUSINESS OR	INDUSTR	Y 11. BIRTHPLACE (Sto	te or foreign	country)	12. CITI	ZEN OF	WHAT	COUNTRY
Housewift		'	- Home		Maryland			TT :	S.A.		
13. FATHER'S NAME					14 MOTHER'S MAIDEN				V161	,	
Jefferso	n Brode				Ada Brig	700 213					
15. WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO	17. INF	DRMANT	Almano	Add	ress			
(Yet no or unknown) (I	f yes, give war or dates of s	ervice)	In role	Sp	ringfield S	tate 1	Hospital 1	Record	8		
	•	use per li	ne for (0), (b), and (c)]	_					INTER	RVAL BET	
PART I. DEAT	H WAS CAUSED BY: IMMEDIATE CAUSE (o	1 B	ronchonneum	onia						TAND	DEATH
4411	DUE TO										
Conditions, if an	y, which) (b										
gove rise to in couse (o), stoting t	mediate										
lying couse lost.	ne <u>under-</u>	4									
Z PART II. OTH	ER SIGNIFICANT CON	DITIONS	CONTRIBUTING TO DEATH	H BUT NO	OT RELATED TO THE TER	MINAL DISEA	SE CONDITION GIV	EN IN PART	1(0) 19	WAS A	UTOPSY
C.B.S. a	ssoc with	pres	enile brain	dise	ase with ps	ych tt :	ic reaction	on.		PERFOR	MED?
C.B.S. S. Decubitus C.B.S. S. Decubitus 200 ACCIDENT WAR OR CONTRIBUTING OR (IF EITHER, NOTIFY)	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER]	20b. DESC	CRIBE HOW INJURY OCC	URRED. (Enter noture of injury ii	n Port I or Po	ort II of stem 18)				
3 20c. TIME OF INJURY	Month, Doy, Yes	or 20d. II	NJURY OCCURRED 20	e. PLACI	OF INJURY (Home, for	rm. 20f (Ci	ly or lowel	(C)	ounty)		(State)
Hour o, m.	19	While	Not while	factor	y, street, office bldg., e	lc.)	,, 0, 101114	101	2011.71		(Sidie)
21. I certify the	at I attended the	deceasi	ed fram June 2	1	1958 ta A	pril 8	3 19 59	9 that I le	ast say	w the c	deceases
	ril 8		9, and that d								
	/ / ·						Street, city or town,		e uuie		TE SIGNED
ACTUAL SIGNATURE	encery -	Lee.	Meaco	`м.с	Springfi	eld S	tate Hosp	ital	4	/8/59	9
PHYSICIAN'S NAME (Type)	Edmund Lu	sthau	s. M.D.		Sykesvil	le. M	arvland				
720. BURIAL, CREMATION			72c. NAME OF CEMETE	RY OR C			ATION (City , town, i	or county):		(State))
F. Here (Specify)	H-11-	39	(kennt	cell	ref	1/4	unterla	sulf	7%	1/	
23. FUNERAL DIRECTOR'S	SIGNATURE OF	- /	ADDRESS AS AS	4.1	240. REL	P 1 0 'S	9 Cat	STRAR'S SIGI		/	
401111111111111111111111111111111111111	A 84 9 114	/	man redu	7,	Well , DAIL			, 40, /	VEALL .		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4161

CERTIFICATE OF DEATH

04149

₽													
1.	PLACE OF DEATH o. COUNTY	Carroll		MARY	LAND	2. USUAL RESI	pence (whila	ere deceased lived nd	If institution b. COUNTY	Balti	e before	odmiss C1	ion) Cy
	B. CITY OR TOWN I	opression (MILST)	ts, write	20yrslmo	26ds	Balti	more	utside corporate lin		5 V 3		est town	ı) √
L	d. NAME OF HOSPIT	Al (If not in hospital, gield State	Hosp	oddress ital		d. STREET A	DDRESS 57	12 Bello	na Ave		e		FARMY X
3.	NAME OF DECEASED (Type or print)	Lore		Middle		Foos lo		4. DATE OF DEATH	Morr	11	Doy		Year 59
	sex Female		WIDOW			2 gamas	arr. A)	1,1884	E (In years birthday) 75 yrs.	Months	Doys	Hours	R 24 HRS Min
10	o. USUAL OCCUPATION during most of world	ON (Give kind of work a	lane 10b.	KIND OF BUSINESS O	R INDUST	RY 11. BIRTHPI	LACE (State	or foreign country)		12. CITI	ZEN OF	WHAT	COUNTRY
L	housework					Ma	rylan	d			U.S.	A	
13.	FATHER'S NAME					14 MOTHER'S	MAIDEN N	IAME					
L		homas E. Fo					Jane	Smith					
15 (Ye	et. no or unknown) j	R IN U. S. ARMED FOR		SOCIAL SECURITY NO	17. IN	FORMANT			Addre	933			
L	no			-		Spr	ingfi	eld St.Ho	sp.Re	cord			
		TH WAS CAUSED BY: IMMEDIATE CAUSE (o DUE TO	A	ne for (0). (b), and (c). rterioscle		Heart	Dise	ase			INTER	rval BE T AND IONT!	TWEEN DEATH DS
	gave rise to i couse (a), stating lying couse lost	mmediate DUE TO	Ge	neralised A								year	
CERTIFICATION		Schizophrer	ic r	contributing to beaction par	ranoi	d type	THE TERMI	NAL DISEASE CON	DITION GIVE	N IN PART	· ·	PERFO	AUTOPSY RMED? NO [
	200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	AS UNDERLYING D CAUSE OF DEATH MEDICAL EXAMINER)	206. DES	CRIBE HOW INJURY O	CCURRED	(Enter noture o	f injury in P	ort 1 ar Port II af i	tem 18)				
MEDICAL	20c. TIME OF INJUR Hour o. m p. m.	Y Manth, Day, Yes 19	While of wor	NJURY OCCURRED Not while	20e. PLA	CE OF INJURY (pry, street, office	Hame, form, bldg , etc	201. (City or 10v	7	(C	ounty)		(Stole)
	actual SIGNATURE	or I altended the	deceas	M 1		accurred at		M, from the ADDRESS (Street, ci	causes a	nd on th		state	deceased ed abave TE SIGNED
22	PHYSICIAN'S NAME (Type)	ONSTAN	(7)	N IVEB.	ER		4K	ESVIL	LE	<u></u>	Str	WY	lang
	Purial (Specify)	4/7/59	•	New Cat			n.	Baltim	ore,	Ld.		45tote	=)
23.	harles E	. Schimur	ek j	Funeral H	ome		24a. REC'D	BY REGISTRAR	24b. REGIST	TRAR'S SIG			

funeral director, aid be filed with may be retained the haspital or attending physician.

TO FUNERAL DIS OR: After this certificate has been signed by the attending physician and completely filled in by page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 sight registrar prior to burial, cremation, or removal, and in any event within 72 haurs after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs of

er death. Page 4

TO HOSPITAL OR VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04150 4162 **CERTIFICATE OF DEATH** Reg. Dist. No. with director, 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) n. COUNTY filed b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give pearest town) RURAL and give nearest town) mos cod d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? Prospect Nursino Home YES NO DE NAME OF Middle 4. DATE Month Day Year DECEASED (Type or print) DEATH 1959 5 SEX AGE (In years last birthday) yrs. 7. MARRIED T NEVER MARRIED T B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS Months Days WIDOWED IN 100. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Carelina MA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME DUNN 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) VTAVIO C 420.0 DUE TO Conditions, if any, which permit gove rise to immediate DUE TO cause (a), stating the underlying couse lost, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19, WAS AUTOPSY PERFORMED? YES \ NO \ 20a. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20d. INJURY OCCURRED Day, (County) (State) factory, street, office bldg., etc.) Hour q. r. White Not white of work □ at work □ p. m. ... 19 9, that I last saw the deceased 21. I certify that I ottended the deceased from. ond that death occurred at 430 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL eg 3 shauld W.B. Cylwell PHYSICIAN'S NAME (Type) 220. BURIAL, CREMATION, 225. DATE THEREOF 22c. NAME OF CEMETERY OR GREMATORY 22d. LOCATION (City, fown, or county) (State)

ADDRESS

24a, REC'D BY REGISTRAR

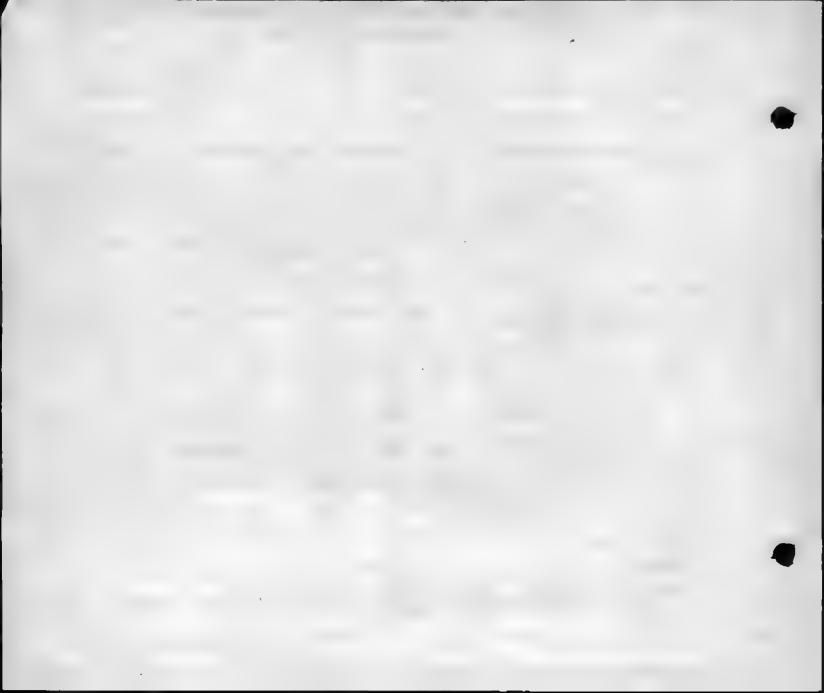
DATE APR 21 '59

24b. REGISTRAR'S SIGNATURE

arthur & Hours

death. Page

23. FUNERAL DIRECTOR'S SIGNATURE



		MARYL	AND	STATE DEPA	ARTM	ENT OF HEAL	TH-BA	LTIMORE, 1						
		4163		CERT	IFIC	ATE OF DEA	TH		() 4151 Reg. Dist. No.					
	o. COUNTY CE	rroll		MAR	YLAND	2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Maryland b. COUNTMontgonery 173								
	b. CITY OR TOWN (IF RURAL and give her Sykesville			c. LENGTH OF STATE 2yrs9mths]		CITY OR TOWN	give ned	irest town) .					
)	d. NAME OF HOSPITA OR INSTITUTION Springfiel	Ld State Ho	spits	address)		d Street Address 7212 Spr		•			e. IS RES ON A YES	FARM2		
	3. NAME OF DECEASED (Type or print)	Ethe	1	Middl		Fowble	4. DATE OF DEAT	1.		Day 2	2	19 59		
	5. SEX Female	6. COLOR OR RACE White	7. MARRI			8. DATE OF BIRTH 6-26-79		9 AGE (In years last birthday) yrs.	Months Months	R 1 YEAR Doys	Hours	R 24 HRS Min		
	Inspector at	ng life, even if retired)	опе 10Ь	KIND OF BUSINESS	OR INDU	STRY 11. BIRTHPLACE (S		country)		S.A.		OUNTRY?		
)	13. FATHER'S NAME	eremiah Elm	5			14. MOTHER'S MAIDE		Gartrell						
	15. WAS DECEASED EVER (Yes, no. or unknown)	IN U. S. ARMED FORG f yes, give wor or dates of se		SOCIAL SECURITY NO		opital reco	rds	Addi	ess					
		TH [Enter only one con H WAS CAUSED BY. IMMEDIATE CAUSE (c)	Ante			Heart Disea	50			ONS	RVAL BE DIA TE	DEATH		
	4.0.0 Conditions, if on	, (D)	Gene	eralized A	rter	iosclerosis				37	ears			
	gove rise to in couse (o), stating the lying couse lost.													
	PART II. OTHI C.B.S., Ce1 20g. ACCIDENTING OR CONTRIBUTING (IF EITHER, NOTIFY)	er significant conc rebral arte	rios c	Clerosis V	rith	NOT RELATED TO THE TE psychotic r	action	SE CONDITION GIV	EN IN PA	RT 1(a) 1'	PERFO	RMED?		
		CAUSE OF DEATH I	20b. DESC	CRIBE HOW INJURY (OCCURRE	O. (Enter nature of injury	r in Port I or Po	ort II of item 1B.)						
	20c. TIME OF INJURY Hour a.m.	Manth, Doy, Yea	While of work	NJURY OCCURRED Nat while t of work		ACE OF INJURY (Home, stary, street, affice bldg.,		ty or town)		(County)		(State)		
	21. I certify the	at I attended the	decease	0		accurred at 3 P	4-26- M, from	, 1 <u>59,</u> the causes an				eceased abave.		
	ACTUAL SIGNATURE	ustini a	el	Campo		Springf	ield S	Street, city or town. tate Hospi	tal.		PAT 4-	26 - 59		

/Agustin del Campo. M.D. PHYSICIAN'S NAME (Type) BURIAL, CREMATION 22d. LOGATION (City, town, or county). (State) 24b. REGISTRAR'S SIGNATURE 24g. REC'D BY REGISTRAR

JU DATE APR 3 0 '59 arthur & Kraus

Sykesville, Maryland



04152 **CERTIFICATE OF DEATH** 4164 Reg. Dist. No. 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. COUNTY b. COUNTY Frederick MARYLAND Marvland Carroll b. CITY OR TOWN (If outside corporate limits, write E. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) RURAL and give nearest fown) 2vr.8mo.16da Rural) Sykesville Thurmont R.F.D. #2 unknown d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? OR INSTITUTION Springfield State Hospital YES NO 3. NAME OF DECEASED 4. DATE Middle Lost Month Yeor OF 1959 Calvin Fox (Type or print) Marshall DEATH ٦0 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED KT IF UNDER 1 YEAR IF UNDER 24 HRS 8. DATE OF BIRTH 9. AGE (In years last birthdoy) Months 8-10-11 Days Male White WIDOWED | DIVORCED [100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. unknown unknown Marvland 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME George Fox Olive Favorite 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address Records Springfield State Hospital no unknown 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Bronchopneumonia IMMEDIATE CAUSE (6) **DUE TO** Rheumatic Heart Disease vears Conditions, if ony, which gove rise to immediate DUE TO couse (a), stating the underlying couse lost. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES 🚺 NO 📋 Schizophrenic Reaction. Hebephrenic type. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while of work I of work I L=10-59 , 19 , that I last saw the deceased 21. I certify that I attended the deceased from 11-21-56 _, and that death occurred at 12:50 M, fram the causes and an the date stated above. olive on April ADDRESS (Street, city or town, stote) DATE SIGNED 4-10-59 ACTUAL Springfield State Hospital SIGNATURE PHYSICIAN'S Walter Knopp, M.D. Sykesville, Maryland NAME (Type) 22d. LOCATION (City, town, or county) 220. BURIAL CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY (Stote) REMOVAL (Specify) U.B. Cem. 23. FUNERAL DIRECTOR'S SIGNATURE CADDRESS/ 24a. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE Circlian & Trans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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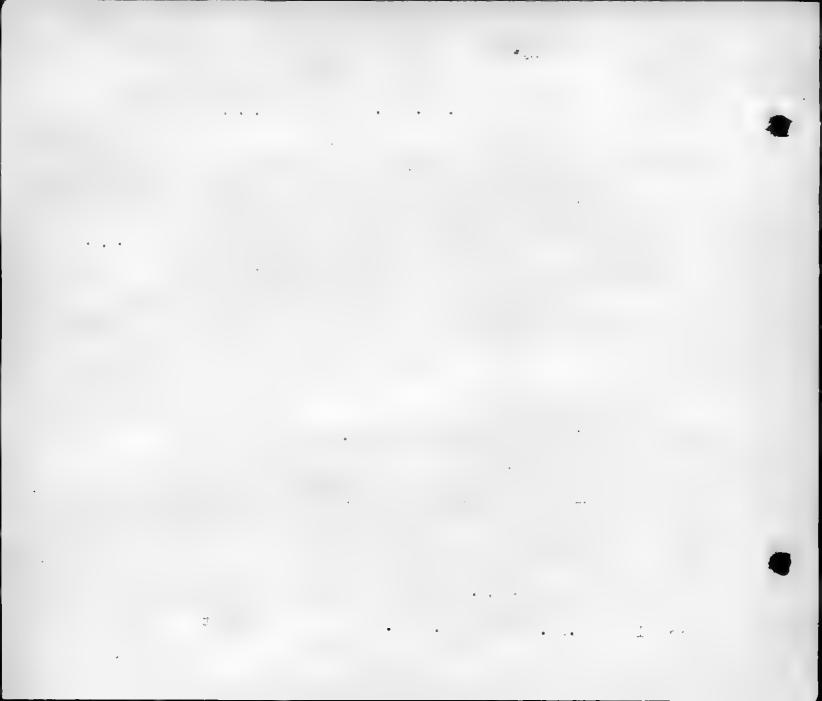
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3 should

TO FUNERAL

the registrar

deoth. ard ard



James F. Scarpelli, Cumberland, Md.

04153

11:54

e IS RESIDENCE ON A FARM? YES NO F

19 37

YES NO.

(Stote)

(County)

VS A15 (4) 15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

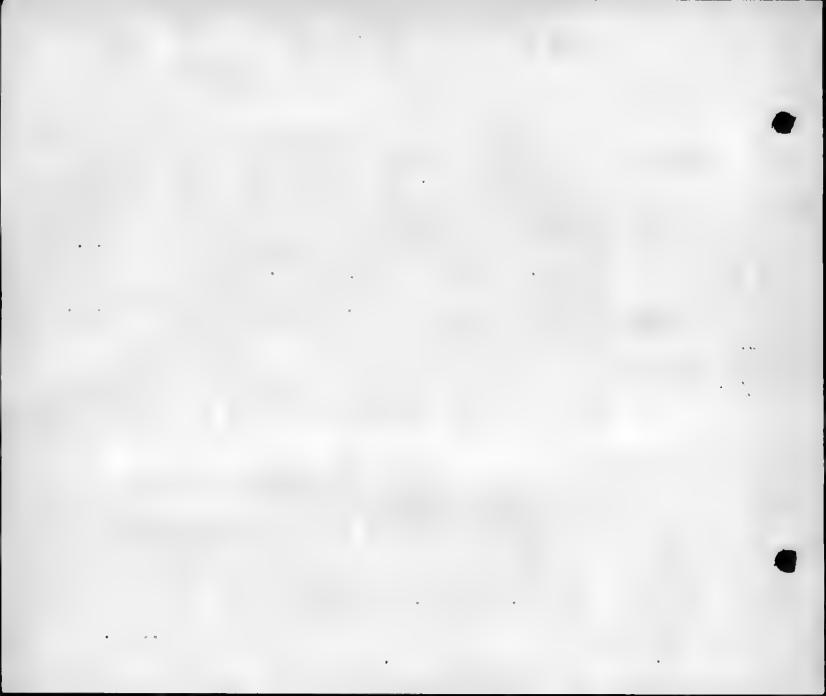
7			4166	5	CERTIF	ICATE	OF DEATH	1		Reg. Dist.	No.	
)	1.	PLACE OF DEATH D. COUNTY	arroll		MARYLA		USUAL RESIDENCE (WE	vland	lived. If institution b. COUNTY	on: Residence Carro	before admiss	ion)
		B. CITY OR TOWN (RURAL ond give a		mits, write	c. LENGTH OF STAY IN	116 с	c. CITY OR TOWN (IF o		rote limits, write R	URAL and give	nearest tawr)
		OR INSTITUTION	TAL (If not in haspital, ullen Nu	. give street アミュアス	oddress) g Home		d. STREET ADDRESS	nut A				IDENCE FARM?
		NAME OF DECEASED (Type or print)	ERNES	First ST	Middle	GRI	lost TAES	4, DATE OF DEATH	Mon APRI		/	Year 19 59
	5. :	nale			RIED A NEVER MARRIED	_	TE OF BIRTH 3-16-1899		9. AGE (In years last birthdoy) yrs.	Months Da	EAR IF UND	
	10a	USUAL OCCUPATION during most of work retired	rking life, even it refire	k done 10b.	Balto. C:		11. BIRTHPLACE (Stote Maryl:	***	ountry)		N OF WHAT	COUNTRY
	13.	FATHER'S NAME	William	J.	Grimes	14.	MOTHER'S MAIDEN N Edna I	_	rfield			
)	15. (Ye	WAS DECEASED EVI , no, or unknown)	ER IN U, S. ARMED FC (If yet, give wor or dates o	ORCES? 16.	7-28-6314	17. INFOR	MANT Gertrud	de M.	Grimes		erie	
/												
			ATH (Enter only one of ATH WAS CAUSED BY: IMMEDIATE CAUSE DUE 1	(0) Co	me for (a), (b), and (c).	ombo	ni, Cerde	in f	ulur,		INTERVAL BE	TWEEN DEATH
		PART I. DE/ 420./ Conditions, if course to incourse to), stating	ATH WAS CAUSED BY. IMMEDIATE CAUSE DUE TOON, which immediate the under-	(b) ar	77"	ombo o ges	nis , Carde	in f.	uelur,	14	HALL 9	TWEEN DEATH
0	CATION	PART I. DE. 4 20.1 Conditions, if a gave rise to i couse (a), stating lying cause lost.	ATH WAS CAUSED BY. IMMEDIATE CAUSE DUE 1 Day, which immediate the under-	(b) Co (b) Or	77"	r ger	nis; Carde	NAL DISEASE	condition GIV	14	to Tyul 9 19. WAS A PERFO	5-9
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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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You		(Type or print)	WA	LTER	D.		GROOMES	OF DEATH	Apri			1959
i for	5.	EX	6. COLOR OR RACE		NEVER MARRIE	8.	DATE OF BIRTH		9. AGE (In years last birthday)	Months Days	R IF UND	DER 24 HRS.
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ا م ا	13.	FATHER'S NAME	L.	7 00	HS of ac of	011	14. MOTHER'S MAIDEN	NAME			, D .	
K 00			David A.	Groo	mes		Anna R	. Dor	sey			
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cld l	190 1	CAUSE OF DEATH.			l and str							
in Spanish	MEDICAL	20c. TIME OF INJUI		or 20d. In While	Not white O	Ge. PLAC facto	E OF INJURY (Home, form y, street, office bldg., etc) 17	er som inst			(State)
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TO DIRECTOR		ACTUAL SIGNATURE	11/1/20	Bres	W/X		M.D. CHIEF MEDICAL EX	AMINER 🔲				SIGNED
nekal moval.		EXAMINER'S	174774	7	, 0		ASSISTANT MEDIC				4/1	3/59
FUNERAL F removal.	270	NAME (Type) - BURIAL, CREMATIO	William N. 1226, DATE THEREO		2c NAME OF CEMET	ERY OR O	DEPUTY MEDICAL		ION (City, town, o	v county)	(Stat	ial .
a a		REMOVAL (Specify)			White			_		or county)	(STO)	e)
A15ME(5)	23.	FUNERAL DIRECTOR	'S SIGNATURE		ADDRESS			D BY REGIST	RAR 24b. REGIS	STRAR'S SIGNATU		
A 9/55	L	C. a.	Waltz,	M T I	field, M	u.	DATE A	PR 15'	59 C	ribun & For	au4	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 ſΗ

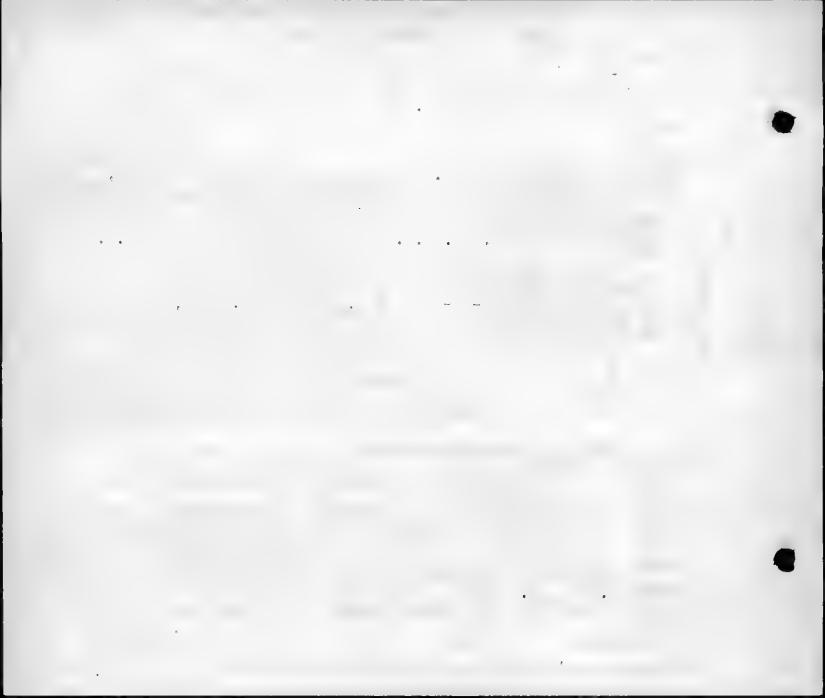
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() 4156 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY	arroll	MARYLAND	II O. STATE	DENCE (Where decease aryland	d lived. If instituti b. COUNTY	Cerroll	ore odmission)					
RURAL ond give ne	f outside corporate limits, write parest, town) 101ne	c. LENGTH OF STAY IN 16	c. CITY OR 1	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) X Woodbine								
d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospital, give stre	et address)	d. STREET A				e. 15 RESIDENCE ON A FARM? YES NO					
3. NAME OF DECEASED (Type or print)	RUFUS	Middle W a	HALL	4. DATE OF DEATH	Mor APh		Year 19 ⁵ 9					
5. sex male	white woo	RRIED NEVER MARRIED DIVORCED	9-25-1	892	9. AGE (In years lost buildoy) Obyrs.	Months Doys	IF UNDER 24 HRS Hours Min.					
10a. USUAL-OCCUPATION during most of work Track for	NGive kind of work done 10 king life, even if retired) Oreman	b. KIND OF BUSINESS OR IND $B_*\& O_*R_*R_*$	USTRY 11. BIRTHPL	ACE (Stote or foreign of aryland	ountry)	U.S.	OF WHAT COUNTRY					
13. FATHER'S NAME				MAIDEN NAME	****							
	William G. H			ie Harris	on							
15. WAS DECEASED EVER (Yes, no. or unknown)	R IN U. S. ARMED FORCES? I (If yes, give wor or dates of service)	6. SOCIAL SECURITY NO. 17.	Mrs. LE	rgaret D.	Hall,	seme						
PART I. DEA 4.20. / Conditions, if an gove rise to for cause (s), storting lying couse lest. PART II. OTH	the under-	ore for (6), (6), and (c). Draw ary The MITTER AND THE SECRIBE HOW INJURY OCCURR				ON!	PAPER DE MASS AUTOPSY PERFORMED?					
	LI CAUSE OF DEATH MEDICAL EXAMINER) Y Month, Day, Year 20d Whi	. INJURY OCCURRED 20e.		Home, farm, 20f. (City		(Counly)	(Stote)					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		\$9, and that deal - Acll IALL	M.D.	5:15 P.M. from ADDRESS (S	n the causes of treet, city or town,	and on the do	ow the deceased te stated above DATE SIGNED					
220. BURIAL, CREMATION REMOVAL (Specify)	4-4-1959	Poplar Sp		Hows	rion (City, town, o	or county) Marylan	(Stole) 1d					
23. FUNERAL DIRECTOR'S		ADDRESS infield, mar	yland	240. REC'D BY REGIST DATE APR 6		strar's signatul rithun S. He						

may be retained the haspital or attending physician.

TO FUNERAL DIRE, DR. After this certificate has been signed by the attending physician and pompierery filled in by Juneral director, page 3 shauld be detached far use as the burial-transit permit. Then please remave carbon/papers, lages 1 and 2 shauld be filed with the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. death! Rolle # TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate Le manufed within 24 hours of my VS A15 (4) 15M 9/55



CERTIFICATE OF DEATH 4168 director, iled with PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission b. COUNTY Baltimore a. COUNTY filed MARYLAND Maryland Carrol 1 death. b. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest fown) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) v Sykesville Kingsville d. NAME OF HOSPITAL (II not in hospital, give street address) d. STREET ADDRESS by 2 5 Springfield State Hospital Temple Lane pup 5 NAME OF DECEASED 4. DATE Middle Month [Type or print] DEATH April HARTMAN Joseph 9. AGE (In years last birthday) 5 SEX 6. COLOR OF RACE letely 7. MARRIED T NEVER MARRIED TH B. DATE OF BIRTH DIVORCED [7] WIDOWED [7] papers. White executed Male 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -Retired-Mechanic oug - Sheet Metal Maryland carbon 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Margaret Mader John Hartman I-menosin List married the hours геллоче 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT Address 212-12-5369 Springfield Hospital Records No 1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic heart disease. IMMEDIATE CAUSE (c) DUE TO ģ ony permit. Conditions, if ony, which Carcinoma of the jaw. (b) gove rise to immediate DUE TO couse (o), stoting the underlying couse lost. burial-fransit PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) 19. WAS AUTOPSY C.B.S. assoc. with senility. 200 ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, [Enter nature of injury in Port I or Part II of item 18.] MEDICAL 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Home, lorm, Day, Year 20d. INJURY OCCURRED 20f (City or town) factory, street, affice bldg., etc.) Hour p. m. Not while of work | of work 21. I certify that I attended the deceased from April 3 ... 1959, to April 8 ... 1959, that I last saw the deceased alive on April 8 , and that death occurred at 8:408 M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) ACTUAL prior Springfield State Hospital shauld ā PHYSICIAN'S Agustin del Campo, M.D. Sykesyille. Maryland FUNER n 220. BURIAL CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL (Specify) 5500 O'Donnell st. Balto. Md. Burial 11-10-1959 Trinity Lutheran 9 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 246 REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR APR 1 0 '59

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

IF UNDER 1 YEAR IF UNDER 24 HRS

Hours

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED? YES TO NO

(Stote)

DATE SIGNED

vears

venrs

12. CITIZEN OF WHAT COUNTRY?

Days

U.S.A.

(County)

e. IS RESIDENCE

YES NOTE

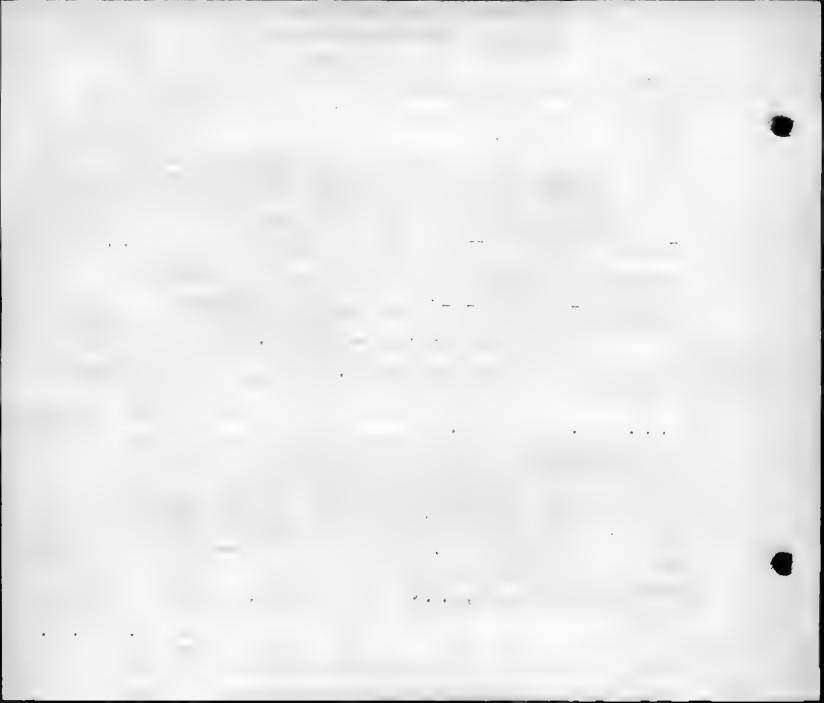
Year

19 59

Reg. Dist. No.

8

Months



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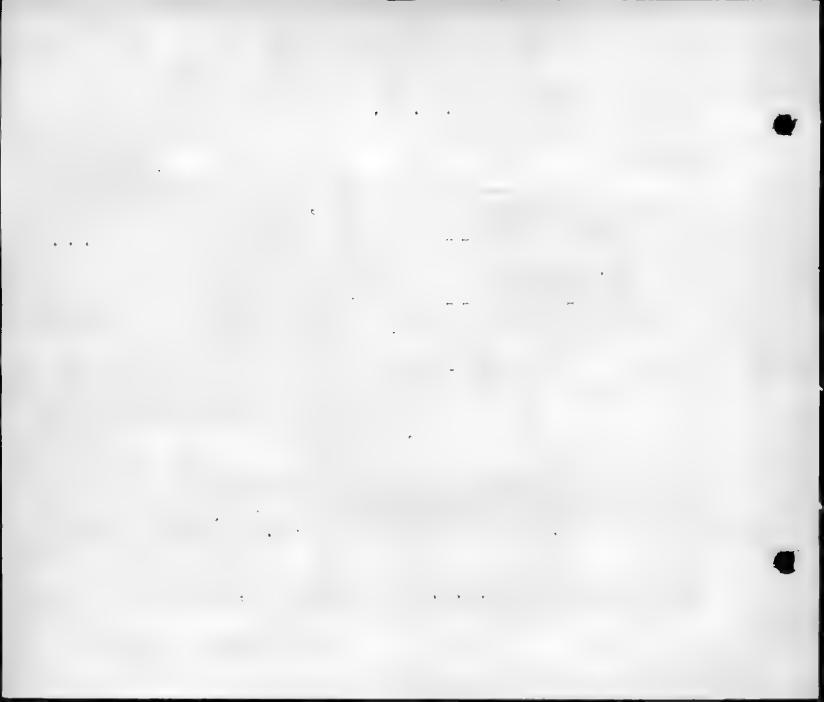
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



VS A15 (4) 15M 9/55 I

	417	0	CERTIF	ICA 1	E OF DEATH	-1		门皇 Reg. Dist. N	159
1. PLACE OF DEATH o. COUNTY Ga	rroll		MARYLA		USUAL RESIDENCE (WI o. STATE Mary)		d. If institutions b. COUNTY	Residence be	The state of the s
b. CITY OR TOWN (If RURAL and give ne	arest lown)		c. LENGTH OF STAY IN		c. CITY OR TOWN (If o		limits, write RUR		
d. NAME OF HOSPITA		give street	oddress)	.1d	d. STREET ADDRESS	2, 25	. IS RESIDENCE ON A FARM?		
3. NAME OF DECEASED (Type or print)	<u>field State</u> Fi Has	rst	. Middle		Lost	4. DATE OF DEATH	Month	1	VES NO Day Year
5. SEX	6. COLOR OR RACE	7. MARI	RIED NEVER MARRIED	_ :	Hermann DATE OF BIRTH	9. A	ost birthday)		21 19 59 AR IF UNDER 24 HRS. 15 Hours Min.
Female 100. USUAL OCCUPATIO during most of works	White N (Give kind of working life, even if retired	WIDOWI done 10b	ED DIVORCED [- 0	une 19, 188		69 yrs.	12. CITIZEN	OF WHAT COUNTR
Teache 13. FATHER'S NAME	r	16	SARGOL		Mary Mary			<u></u>	U.S.A.
John T	. Hermann	CES2 14	SOCIAL SECURITY NO	17. INFC		Maggie M	cCulley		
(Yes, no or unknown) (I	If you, gave war or dates of		Thick		ringfield S	tate Hos			
	TH [Enter only one of TH WAS CAUSED BY: IMMEDIATE CAUSE (DUE TO	Ar	ne for (o). (b), and (c)] teriosclerat	ic c	ardiovascul	ar disea	se		Tears
Conditions, if an gove rise to in cause (a), stating t	y, which)	And	emia - Essen	tial					Months
20g. ACCIDENT WAS	Schizoph s underlying [] [] CAUSE OF DEATH	iditions d ireni	CRIBE HOW INJURY OCC	hebe	phrenic typ	е		I IN PART I(o)	19. WAS AUTOPSY PEPFORMED? YES NO
O (IF EITHER, NOTIFY I	MEDICAL EXAMINER) / Month, Doy, Ye 19	or 20d II While at wor	Not while	e PLACE factor	OF INJURY (Home, form r, street, office bldg., etc	n, 201 (City or to	own)	(Count	ly) (Stole)
	Venstand	deceas 19_1 14	ed from Novemb 59 and that de		corred at 5:10		e causes and	d on the c	
PHYSICIAN'S K	Constantin	Webe	r. M. D.		Sykesy	ille, Ma	ryland		was the title titl
220 BURIAL, CREMATION REMOVAL (Specify)	14-24	-54	22c. NAME OF CEMETE	RY OR C		228 LOCATION	(City, town, or i	county)	(Store)
23 FUNERAL DIRECTOR'S	SIGNATURE	Lac	Lecrost sala	ed,	/	D BY REGISTRAR PR 2 8 '59		Lun & H	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



VS A15 (4) 15M 10/57

13

CERT	IFICATE	OF	DEATH
		•	

		4	171	CERTIFIC	CAT	E OF DEA	TH		Reg. Dist	. No.	Ü
1	1. PLACE OF DEATH				2	USUAL RESIDENCE	(Where decease	ed lived. If institu	tion: Residence	before o	admission)
1	6. COUNT	Carroll		MARYLAN	ED	o. STATE Mary	land	%. COUNT	arrol	1	
	b. CITY OR TOWN RURAL and give	(If outside corporate limits	, write	c. LENGTH OF STAY IN I	ь	c. CITY OR TOWN	(If outside corp				it tawn)
	rural-	-Mt. Airy		37 yrs.	- X	rurt	lMt.	Airy			
	d. NAME OF HOSE OR INSTITUTION	TTAL (If not in hospital, gr	ve street	oddress)	1	d. STREET ADDRES	SS			e.	ON A FARM?
`						Tayl	orsvil	le			ES NO
	3. NAME OF DECEASED	First	1	Middle		Last	4 DATE	Mo	anth	Doy	Year
	(Type or print)	CARRI	E	0.	Ţ,	OOPER	OF DEATH	APnl	L 3		19 59
	5. SEX	6. COLOR OR RACE	7. MARR	TED NEVER MARRIED] B. D	ATE OF BIRTH		9. AGE (In year	IF UNDER I	YEAR IF	UNDER 24 HRS
	female	white	WIDOWI	DIVORCED	1 12	-10-190	3	last birthdoy)	Months E	Days H	lours Min
	100 USUAL OCCUPAT	ION (Give kind of work derking life, even if retired)	one 10b	KIND OF BUSINESS OR IN	IDUSTRY	11. BIRTHPLACE (S	State or foreign (country)	12 CITIZ	ZEN OF V	WHAT COUNTRY?
	- 1	Sevife	1	lome		Maryl	and		U	.S.	
	13. FATHER'S NAME				1-	MOTHER'S MAID	EN NAME				
		Charles 1	Merc	er		Lavin	ia Poo	1 e			
l.	15 WAS DECEASED EN	/ER IN U. S. ARMED FORCE	ES? 16.	SOCIAL SECURITY NO. 1	7. INFO	RMANT		Ad	dress		
1	no	In yes, give nor or come or ser	wice)		Mr.	Jesse :	Hooper	, sam	le .		
	18. CAUSE OF D	EATH [Enter only one cou	se per fir	ne for (a), (b), and (c).]			_			INTERV	AL BETWEEN
	PART I. DI	EATH WAS CAUSED BY: IMMEDIATE CAUSE (o)		The our or	4/	oc.	lusio	-		ONSET	AND DEATH
	420.1	DUE TO		(1						
	Conditions, if	any, which) [b).									
	gave rise to couse (o), statin	immediate (DUE TO			-						
	lying couse lost										
	PART II. O	THER SIGNIFICANT COND	ITIONS C	ONTRIBUTING TO DEATH	BUT NO	RELATED TO THE T	ERMINAL DISEA	SE CONDITION G	IVEN IN PART	1(0) 19	WAS AUTOPSY PERFORMED?
	PART II. O										ES NO
	200. ACCIDENT V	VAS UNDERLYING G CAUSE OF DEATH	20b. DES	CRIBE HOW INJURY OCCU	RRED. (E	nter nature of injur	y in Part I or Pa	rt II of item 18)			
		Y MEDICAL EXAMINER)									
	20c. TIME OF INJU		20d. IN		. PLACE fectory	OF INJURY (Home, street, office bldg.	form, 20f. (Cit	y or town)	(Co	ounly)	(Stote)
	p. m	18	ot work	Not while	,						
	21. I certify	that I attended the	deceas	ed from 3/13	159	, 19, to_	4/3/	59 19	that lc	ast saw	the deceased
	ofive on	4/3/59		, ond that de	. ,						
	-	741					ADDRESS (Street, city or town	i, state)	- 00.0	DATE SIGNED
	ACTUAL SIGNATURE	M.E. Rol	serl	son	M.D.	Hew !	Vind	ser.	mod		
1	PHYSICIAN'S	, ,									
	NAME (Type)	M. E. ROB	ERTS	SON							
		ON, 225. DATE THEREOF		22c. NAME OF CEMETER	Y OR CR	EMATORY	22d LOCA	TION (City, tawn,	or county)		(State)
	REMOVAL ISPECIF	4-6-195	9	Taylors	/ill	.е	Carr	oll Co.	, har	yla	nd
	23. FUNERAL DIRECTO	- 1 44	737.5	ADDRESS		240.	REC'D BY REGIS		SISTRAR'S SIGN		
	C. II.	Waltz,	W 1,1	nfield, Mar	yLai	IC. DATE	APR 6	59	Tarling 9	46	



may be retained. The haspital ar attending physician. O FUNERAL DIRECTOR After this certificate has been signed by the attending physician and campletely filled in by it inneral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, crematian, or removal, and he event within 72 haurs ofter death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours offer death. Roge 4

may be retained TO FUNERAL DIRE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH 4172

() 4161 Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY	Carroll		MARYLAN	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Carroll						
RURAL and give no			c. LENGTH OF STAY IN T				limits, write R	URAL and give	nearest (lown)
	Sykesvill		18 mo.			ykesvi	TTE			
OR INSTITUTION	At (is not in Respire), g	IAM SILEGI I	2001ess)	d. STREET		berty	Road		0	RESIDENCE N A FARM?
3. NAME OF DECEASED (Type or print)	Fir	/IAM	Middle	HOOVER	st	4. DATE OF DEATH	Man API		Doy	Yeor
5. SEX			Gr. IED ☑ NEVER MARRIED [ri-i		AGE (In years	IF UNDER TY		19 59 NDER 24 HRS
male	white	WIDOWE					last birthday)	Months Da		
10a USUAL OCCUPATIO	ON IGive kind of work	lane 10b.	KIND OF BUSINESS OR IN			or foreign coun		12 CITIZE	N OF WI	HAT COUNTRY
Lercha	king life, even it retired	1 1	Is.rdware		aryla			U	.5.	
13. FATHER'S NAME			zetz er-etz e	14. MOTHER'S					4~4	
	Edward C	. Ho	over	Mat	ry S	. Guy				
15. WAS DECEASED EVE			SOCIAL SECURITY NO. 1	7. INFORMANT			Addi	ess		
Yes, no. or unknown) YOS	(II) yes, give war or dates of s	[2]	12-09-5490	Mrs. M	rgar	et R.	Hoover	se se	me	
3	the <u>under</u> DUE TO (c)	her ditions o	ONT BISENSE	BUT NOT RELATED TO	THE TERMI	NAL DISEASE C	ONDITION GIV		PE	AS AL TOPSY REFORMED? NO
OR CONTRIBUTING	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)						,			
Hour a. fi.	Y Month, Day, Yea	While at work	_ Nat while	PLACE OF INJURY foctory, street, affic	(Home, farm, e bldg., etc.	, 20f. (City or	town)	(Coun	nty)	(efol2)
ACTUAL SIGNATURE PHYSICIAN'S NAME (Typo)		. 12 S		ath occurred at			he causes a t, city or town,	nd an the	t saw ti date st	ne deceased ated above DATE SIGNED
220. BURIAL CREMATIO REMOVAL (Specify)	4-21-19		22c. NAME OF CEMETER Loudon I	YOR CREMATORY Park Cem	ty		N (City, lawn, a		{5	ilate)
23. FUNERAL DIRECTOR			ADDRESS		- 17	BY REGISTRAL		TRAR'S SIGNA	TURE	
C. M.	Waltz,	Win	nfield, Md.	•	DATE AP	R 2 1 '59	avi	Chun & 16.	aud	

Coronally throm Bosis, Relemble-sin henry Pisense, Fraducarding Complete NEARTBIBLE - Arthitis

1947

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15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14 TE OF DEAT				Ī		(14	162	7
CATE OF DEATH	1			R	eg. Di	st. No	,	
o. STATE Maryl	-		If institution	on.		ce bef	_	sion)
c. CITY OR TOWN [If o	utside corpo	orate lin	nits, write R	UR.	AL and	give ne	arest taw	n)
ays Elli	cott	C1	ty	1	ا	:	.4	
d street address Columbia	Pike)					ON	SIDENCE A FARM? NO TO
Lest	4. DATE		Моп	th		D	ру	Year
Jones	OF DEATH		Apr	1	1	_1	8	1959
8-21-71		9 AG	E (In years birthday) yrs	-	UNDER	PER PER	Hours	ER 24 HRS Min
DUSTRY 11 BIRTHPLACE (Stote Maryl	-	ountry)		_	12. CI1	U.		A.
14. MOTHER'S MAIDEN N	IAME							
Jose	phine	9 5	sche]					
Hospita	1		Adde			svi	lle	
	***************************************						ERVAL 8	ETWEEN
nonia							19"	lays
ut not related to the termi	NAL DISEAS	E CON	DITION GIV	EN	IN PAR	T 1(a)	19. WAS PERFO YES	
RED. (Enter nature of injury in I	Part I or Por	t II of i	tem 18)	_				7 4291
PLACE OF INJURY (Home, form factory, street, office bldg., etc.	, 20f. (Cit)	or tow	n)		(County	}	(Stote)
, 19 <u>58</u> ., 1a	4-1	8	1959	.1	hat I	last s	aw the	decease
th occurred at 10:1	DM, from	n the	couses o	nc	an t	he do	ite stat	ed abave
M.D. Springfie								-19-5
Sykes	vill	e,	Mary	1	and		- No. No. dds dan by. on	
OR CREMATORY		,	City, town, o	or c	ounty)		(Sto	
k	Balti							Md.
m Place	D BY REGIST		24b. REGIS			4		
DATE AP	RZI'S	9	Ch	W.	w1 8.	7810	ud	



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4174 **CERTIFICATE OF DEATH**

04163Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. COUNTY Maryland Balto.City c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) Baltimore d STREET ADDRESS IS RESIDENCE 5218 York Road YES NO TO 4. DATE Month DEATH Jordan April 10 19 59 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH Months March 25, 1908 U.S.A. Maryland 14 MOTHER'S MAIDEN NAME Anna Robinson 17. INFORMANT Address Springfield Hospital Records INTERVAL BETWEEN ONSET AND DEATH Years PERFORMED? YES X NO T

24b REGISTRAR'S SIGNATURE

alley & House

24s. REC'D BY REGISTRAR

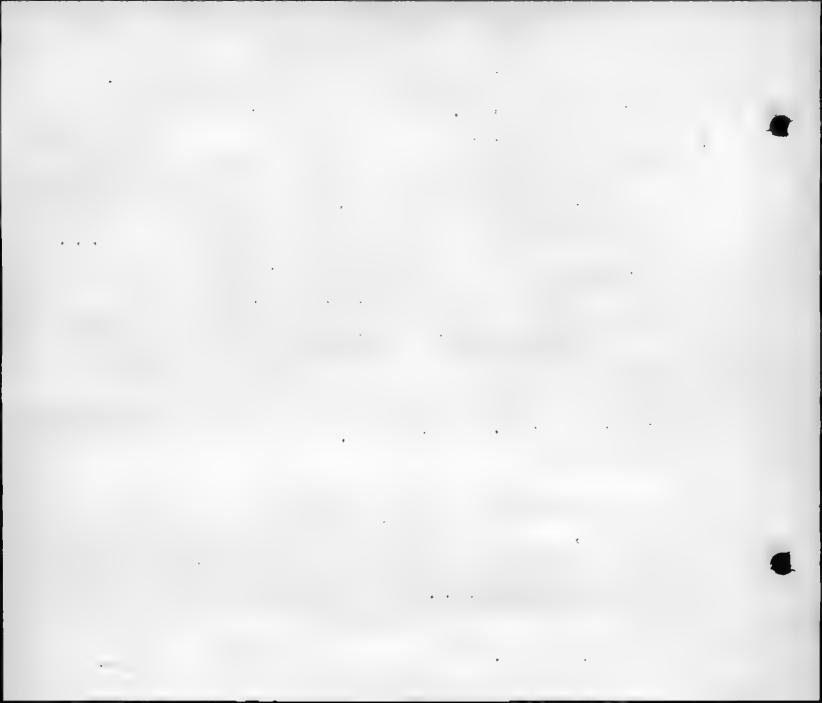
1. PLACE OF DEATH o. COUNTY MARYLAND Carroll b. CITY OR TOWN [If autside corporate limits, write c LENGTH OF STAY IN 16 RURAL and give nearest town) Svkesville lmo.ldav d NAME OF HOSPITAL (If not in haspital, give street address)
OR INSTITUTION Springfield State Hospital NAME OF DECEASED Middle (Type or print) Daisy Anna 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DE S. SEX WIDOWED | DIVORCED [7] Female White 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) 13. FATHER'S NAME Parker Jordan IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Nο 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Rheumatic heart disease **DUE TO** Conditions, if ony, which (b) gave rise to immediate **DUE TO** cause (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19 Schizophrenic reaction. Decubitus ulcer. 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] 20c TIME OF INJURY Month. Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or lown) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not while of work of work 21. I certify that I attended the deceased from March 9, 1959, tApril 10, 1959, that I last saw the deceased ___, and that death accurred at 6:00A_M, from the causes and on the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED Marion Springfield Hospital PHYSICIAN'S Edmund Lusthaus, M.D. Sykesville, Maryland 220. BURIAL, CREMATION. | 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City town, or county) (Stote) REMOVAL (Specify) New Cathedral Cemetery Baltimore, ...d BURTAL 4-13-59

ADDRESS

Wm. Cook, Inc. # 1217 St. Paul Street

VS A15 [4] 15M 9/S5

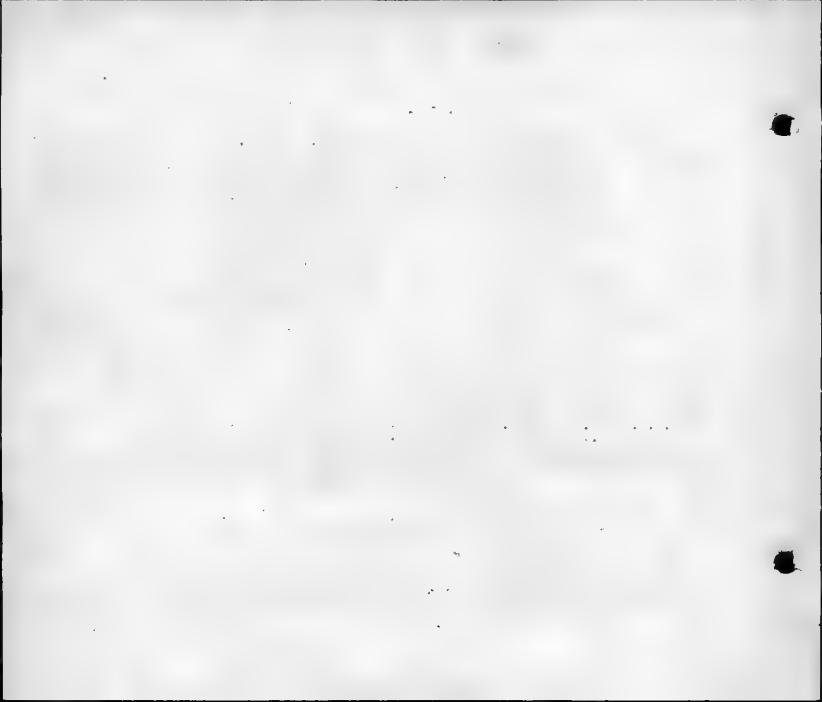
23. FUNERAL DIRECTOR'S SIGNATURE



	MARYLA	ND STATE DEPARTA	MENT OF HEALTH	-BALTIN	10RE, 18	0416	34
	2.1	75 CERTIFIC	ATE OF DEATH	1	R	leg. Dist. No.	, x
1. PLACE OF DEATH o. COUNTY	rroll	MARYLAND	2. USUAL RESIDENCE (Who o. STATE Mary)		d. If institutions b, COUNTY	Residence before on Balto.Cit	
b. CITY OR TOWN RURAL and give r Sykesvil		Lyrs. Linos. 7da	c. CITY OR TOWN (IF or	-	limits, write RUR	AL and give nearest	,
OR INSTITUTION	TAL (If not in hospital, give : eld State Hos	· ·	d. STREET ADDRESS 817 E. 17th	st.		0	RESIDENCE ON A FARM? S NO
3. NAME OF DECEASED (Type or print)	First Willia		Ket tler	4. DATE OF DEATH	April	20,	Yeor 1959
5. SEX Male	0 70 0 1	MARRIED NEVER MARRIED TO	September 26,	, 1876 8	ist birlhday) N	UNDER 1 YEAR IF L	JNDER 24 HRS. Durs Min.
during most of wor	king_life, even if retired)	106. KIND OF BUSINESS OR INDI	C	or fareign cauntr	r)	12. CITIZEN OF W	
13 FATHER'S NAME Frederi	ck Kettler		14 MOTHER'S MAIDEN N	AME eth Stru	8		
15. WAS DECEASED EV	R IN U. S. ARMED FORCES'		Springfield Ho	ospital	Records		
	ATH [Enter only one couse ATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO	per line far (o), (b), and (c).] Bronchopneumoni					L BETWEEN
Conditions, if a gove rise to couse (a), stating lying couse lost.	mmediate Dur 70						
A DPAST II OT	HER SIGNIFICANT COND.TI	ONS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMI	HAL PISEASE CO	ADITION SIVEN	N PART 1(0) 19. W	AS AUTOPSY

YES NOT nsychotic reaction. 200 ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) MEDICAL 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY 20d. INJURY OCCURRED 20f (City or Iown) (County) (State) foctory, street, office bldg., etc.) Hour a.m Not while at work at work to April 20. 59, that I last saw the deceased 21. I certify that I attended the deceased from March and that death accurred at 12:20AM, from the causes and an the date stated above. alive on April ADDRESS (Street, city or lown, state) DATE SIGNED Springfield State Hospital ACTUAL SIGNATU Agustin delCampo, M.D. Sykesville, Maryland PHYSICIAN'S NAME (Type) 220- BUR AL, CREMATION, REMOVAL (Specify) 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City town, or county EUNERAL DIRECTOR'S SIGNATURE 240 REC'D BY REGISTRAR arthur & House

VS A15 (4) 15M 9/55



VS A15 (4) 15M 10/57

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ARYLAND	STATE DEPARTMENT	OF HEALTH—BALTIMORE,	18

4176 **CERTIFICATE OF DEATH**

M

()4165 Reg. Dist. No.

	Keg. Dist	. 140.
1. PLACE OF DEATH © COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence o. STATE b. COUNTY	before admission)
CEPFO//	mayland (art	0//
b. CITY OR TOWN (If outside corporate limits, write RURAL dng give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and gr	re nearest town)
Malatice mil 45 years	X Palabaco". Them the	ud_
d. NAME OF HOS ITAL (If not in hospitol, give street address)	d. STREET ADDRESS	e IS RESIDENCE
OR INSTITUTION	6 hours	YES NO Z
3. NAME OF First Middle	Losi 4. DATE Month	Day Year
(Type or print) Howard Benjamin	Ridd DEATH Gpril	29 19 59
5. SEX , 6. COLOR OR RACE 7 MARRIÉD NEVER MARRIED 1		YEAR IF UNDER 24 HRS
MA/e WILL WIDOWED DIVORCED	Gotober 3. 1876 82 yrs Months D	Pays Hours Min
10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUS during most of working life, even if retired)	STRY 11. BIRTHPLACE (State or foreign country) 12 CITIZ	EN OF WHAT COUNTRY
Labored terral,	Maryland	1.5 A
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	8000
Lloyd N. Kidd	Marioret Riley	
	NFORMANT	
(Yes no. or unknown) (If yes, give wor or dates of service) 218-03693.1	MrRobeit Kidd Patapson	Md
1B. CAUSE OF DEATH [Enter only one couse per line for (o). (b), and (c).]		INTERVAL BETWEEN
PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (0)	Myucarditis	ONSET AND DEATH
2/ 2 2 / DUE TO /	101010	
Conditions, it any, which) (b) Grtorio-Sole)	11 to landi-laguelen Deserce	,
gave rise to immediate Dur TO	VI CON VICE CONTRACTOR	
trice cours land		
lying cause lost. (c)		L.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I	1(a) 19. WAS AUTOPSY PERFORMED? YES NO SE
20b. DESCRIBE HOW INJURY OCCURRED OR CONTRIBUTING CAUSE OF DEATH	D. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING TO TOUSE OF DEATH ITE EITHER, NOTIFY MEDICAL EXAMINER	**	
	ACE OF INJURY (Home, form, 20f. (City or town) (Co	
	clory, street, office bldg., etc.)	runty) (State)
Hour o. m. 19 While Not while fool you work of work of work		
21. I certify that battended the deceased from Alarch 30	1957, to april 29, 1959, that I la	et cau the decease
alive on 4PFIX 11 1959, and that death	1 10	
direction dealers and the dealers	•	
ACTUAL COLLEGE OF THE STATE OF	ADDRESS (Street, city or town, stote)	DATE SIGNED
SIGNATURE SIGNATURE	4.D. Hamp oliva May 6	cal 4/29/1
PHYSICIAN'S 1. 10 SEP/ F. BUSK MID	HAMPSTEAD MAN	land.
220. BURIAL, CREMATION, 226. DATE THEREOF 220 NAME OF CEMETERY OR	R CREMATORY 22d. LOCATION (City, town, or county)	(Cantal
REMOVATER (19) 5-2-59 Carrollton Chu		and (State)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR 24b REGISTRAR'S SIGN	NATURE
John R. Byers Westwinster, Maryland	DATMAY 1 '59 Carthur & H	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 **CERTIFICATE OF DEATH** 4177 Reg. Dist. No be filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY o. State Carrol1 b. COUNTY MARYLAND Carrol1 b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Rural and give negrest fown)
Rural Taney town Rural. Taney town 34 Years d. NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Taney town, Md. R. D. 2 Taney town, Md. R. D. 2 YES NO 3. NAME OF Middle Year GF DEATH (Type or print) Stewart Franklin King Anril: 24: 1959 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH AGE (In years last birthdoy) IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Male White WIDOWED P DIVORCED [7] April 15. 1888 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) during most of working life, even if religed) 12. CITIZEN OF WHAT COUNTRY? Farm (Retired) U.S.A. Retired Farmer Adams Co., Pa. 13. FATHER'S NAME James B. King Elizabeth C. Pepple 15. WAS DECEASEDEVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17. INFORMANT Address None Miss Carrie M. King, Littlestown, Pa. R.D.1 No 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN S & NOS PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) rterioschemis **DUE TO** Conditions, if any, which] gave rise to immediate DUE TO couse (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES INO IN 20g. ACCIDENT WAS UNDERLYING OF ON CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in and I or Port II of item 18.) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (County) (State) Hour a. n. factory, street, office bldg., etc.) Not while at work at work 21. I certific that I attended the deceased from 19-7.that I last saw the deceased and that death accurred at 1/3 25 P.M. from the causes and an the date stated above alive on f ACTUAL SIGNATURE ploods PHYSICIAN'S NAME (Type) BURIAL, CREMATION 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lawn, or county) (State) REMOVAL (Specify) Mt. Carmel Cemetery Littlestown. Adams Co. 0 PUÑERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Littlestown. Pa. Ciriling & House DATE

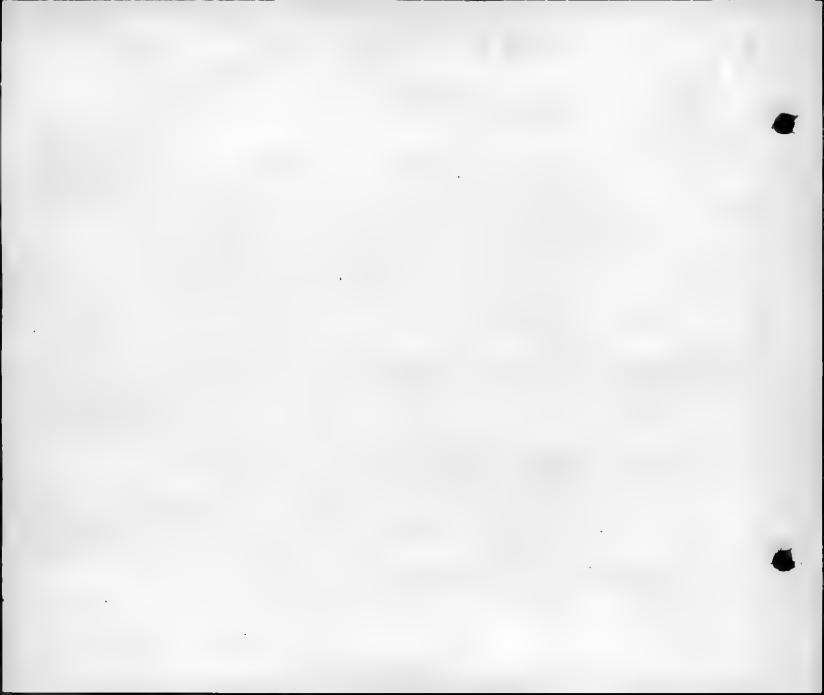


Reg. Dist. No. 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) e. IS RESIDENCE ON A FARM? YES NO IF UNDER 1 YEAR IF UNDER 24 HRS Months Days 12. CITIZEN OF WHAT COUNTRY? U.S.A. INTERVAL BETWEEN ONSET AND DEATH Years PERFORMED2. YES NO (County) (State) 1959 that I lost sow the deceased and that death occurred a3:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, stote) DATE SIGNED Springfield State Hospital 22d. LOCATION (City, town, or county) (Stote) Marvland 24a. REC'D BY REGISTRAR 24b REGISTRAR'S SIGNATURE B. Danzansky & Sons - 3501 14th Street, N.W.

DATE MAY

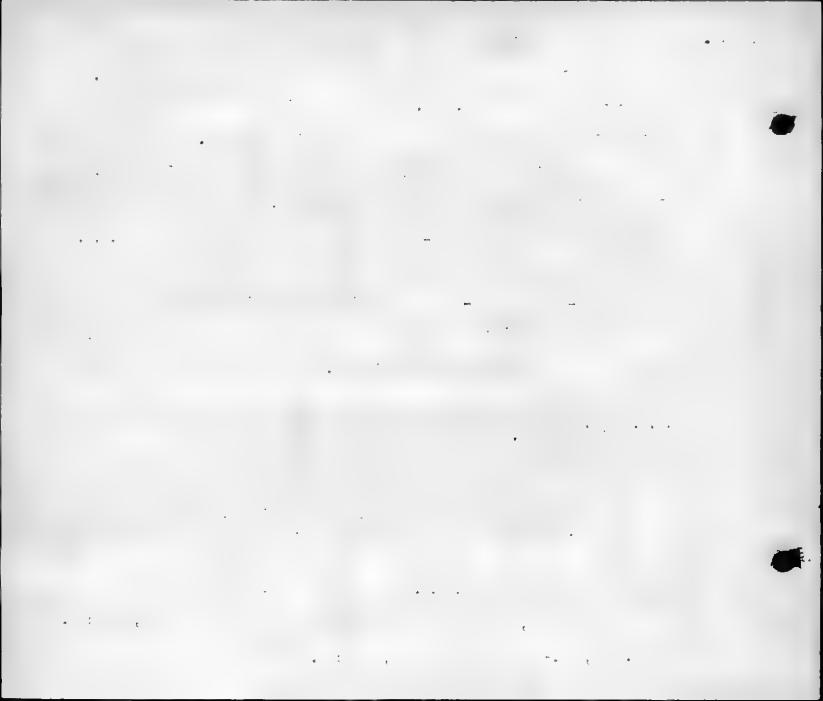
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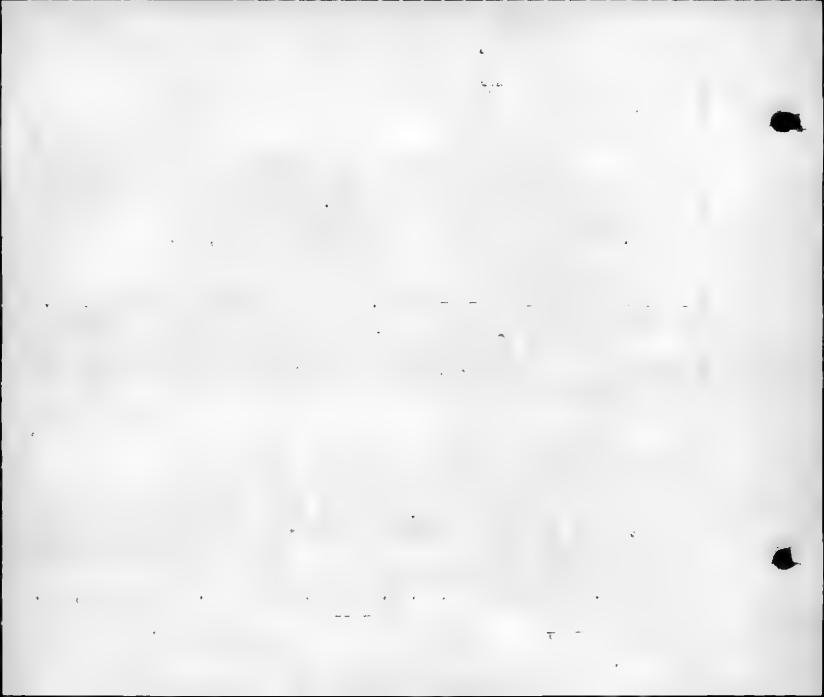


04169**CERTIFICATE OF DEATH** 4150 Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY pay **b. COUNTY** MARYLAND Carroll Maryland Balto.City b. CITY OR TOWN (If autside carporale limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lawn) lyr.umos.20days Baltimore 13 Sykesville d NAME OF HOSPITAL (If not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 3132 Cliftmont Ave. YES NOTE NAME OF DECEASED 4. DATE Middle Day Manth April 20. 1059 William Patrick Leonard DEATH (Type or print) 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 9. AGE (In years fast birthday)
52' yrs. B. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX etely Months Days Haurs September 9.1906 Male White WIDOWED | DIVORCED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Maryland U.S.A. Laborer 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Michael Leonard Cecelia Kelley 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address Springfield Hospital Records No 1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH Mitral Stenosis PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o). veara 410 X Rheumatic Heart Disease. Canditions if any, which years gave rise to immediate DUE TO cause (a), stoting the underlying cause last. C. B.S. assoc. with other diseases of unknown or uncertain cause with YES FI NO! psychotic reaction. 200. ACCIDENT WAS UNDERLYING []
OR CONTRIBUTING [] CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, [Enter noture of injury in Part I ar Part II of item 18] MEDICAL 20c. TIME OF INJURY Month, 20e. PLACE OF INJURY (Hame, form, | 20f. (City or town) Day, Year 20d INJURY OCCURRED (County) (Slote) factory, street, office bldg , etc.) O m Not while at work at work 21. I certify that I attended the deceased fram November 30, 1957, to April 20, 1959, that I last saw the deceased glive on April 20 and that death occurred at 7:15P M, from the causes and an the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 4/21/59 Springfield State Hospital shauld O FUNERAL E page 3 shault PHYSICIAN'S NAME (Type) Agustin delCampo, M.A. Sykesville, Maryland 22d LOCATION (City, lown, or county) Edmondson Avenue, Balto: Md. 22a. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) April 24,1959 New Cathedral Cemetery Burial O **ADDRESS** 24b. REGISTRAR'S SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE 24g. REC'D BY REGISTRAR George J.Ruth_Inc.-1735 Harford Avenue, Balto:Md. APR 2 4'59 VS A15 (4) Clothur & Famue 15M 9/55

death:



1		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
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directo	引)	1. PLACE OF DEATH o. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll
[]		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Fenksburg C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Finksburg
by 1	X	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R 1 Bethel Road OR INSTITUTION R 1 Bethel Road ON A FARM? YES NO K
lled in b		3. NAME OF PECEASED (Type or print) 3. NAME OF DECEASED (Type or print) 3. NAME OF DECEASED (Type or print) 4. DATE Month Day Year OF DEATH April 22 1959
erek filled		5. SEX Male 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH Sept. 8, 1879 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Doys Hours Min. White Widowed Divorced Sept. 8, 1879
nd cample in papers. death.		100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) ret. Farmer Farm Carroll County, Md. USA
		13. FATHER'S NAME HOWARD Lockard 14. MOTHER'S MAIDEN NAME Mary Read
oleun cermicule be altending physician at please remaye carbo within 72 haurs after		15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Address 215-14-2485 W. Holmes Lockard R 1 Finksburg, Md.
		18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) ONSET AND DEATH ALM 342000
ed by the ormit. Then any event		Conditions, if ony, which) (b) Cardin Vascular Discourse who 57car
ian. en signed esit pern and in a		gove rise to immediate code (a), stating the under-lying cause last. Code (a), stating the under-lying cause last.
physicia as beer ial-tran	1	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) OR CONTRIBUTING CAUSE OF DEATH
ending ficate h the bur		
r this certifar use as crematian,		20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED Hour o. m. 19 While Not while at work of two others of two others are not work of two others. 20e. PLACE OF INJURY (Home, form, form, form, form, form, affice bldg., etc.)
R: After tached for burial, cr		21. I certify that I oftended the deceased framation again, 1954, to Capril 28 d., 1959, that I lost saw the deceased alive on again 22, 1959, and that death occurred of 230 M, from the causes and on the date stated above
- 8 2		ACTUAL SIGNATURE To Billion & Cen M.D. Westmireture Dury, 4-23-3
be retaine IERAL DIR 3 shauld gistrar pri	1	PHYSICIAN'S C. L. Billingslea, M. D. 1 S. Center St. Westminster, Md.
may be retained FUNERAL DIRE page 3 should be the registrar prior		220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. Date THEREOF 22c. NAME OF CEMETERY OR CASHATORY Sandymount, Maryland 22d. LOCATION (City. town, or county) Sandymount, Maryland
VS A15 (4) 15M 9/55	52	23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Maryland DATE 240. RECID BY REGISTRAR'S SIGNATURE APR 2759 DATE APR 2759
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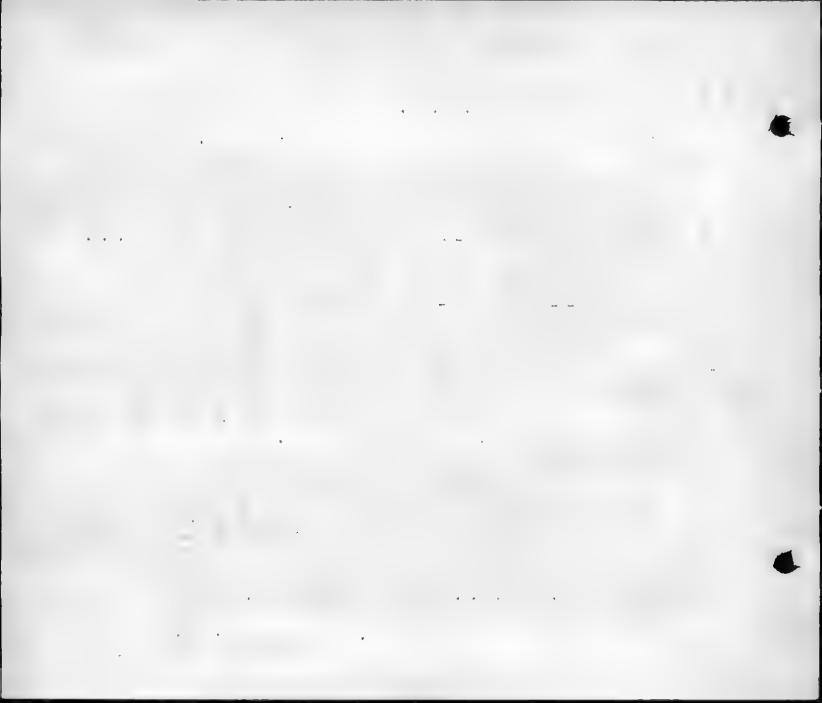
te has been signed by burial-transit permit.

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physician

by 23



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 6, Film 6241, 4/16/50 CERTIFICATE OF DEATH Reg. Dist. No. with . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY filed **b** COUNTY MARYLAND Carroll Maryland Balto.City b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) 8 RURAL and give negrest fown)
Sykesville days Baltimore should d NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. 15 RESIDENCE OR INSTITUTION Springfield State Hospital 1929 St.Paul St. YES NO puo NAME OF 4. DATE First Middle Month Day Year April 1959 Mabel McHugh DEATH (Type or print) 10. 9. AGE (In years last bighday) 68 yrs. 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED | IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX B. DATE OF BIRTH Months Doys Hours 1890 Female WIDOWED K DIVORCED | December 14. 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stole or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired)
HOUSEWILE West Virginia U.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Samuel Crawford Hattie Crawford 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address John McHugh 214-18-2857 St. Paul St. 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH ᇻ PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Encephalomalacia of the right cerebral hemisphere weeks DUE TO Cerebral arteriosclerosis vears Conditions, if ony, which te has been signed buriol-transit perm gove rise la immediate **DUE TO** couse (o), sloting the under-Generalized arteriosclerosis vears lying couse lost. C.B.S. due to cardiovascular accident.

19. Was autopsy performed? CERTIFICATION PERFORMED? 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port 1 or Port II of item 18.) 20c. TIME OF INJURY Month. 20d INJURY OCCURRED 20e. PLACE OF INJURY IHome, form, 20f (City or fown) Day, Year (County) (Slole) factory, street, office bldg , etc.) Hour a m. Not while at wark all wark 1959, ta April 10, 1959, that I last saw the deceased 21. I certify that I attended the deceased from April 4. alive an April 9 and that death accurred at 11:10A M, from the causes and an the date stated above ADDRESS (Street, city or town, state) DATE SIGNED 4/10/59 ACTUAL SIGNATURE Springfield Hospital ploods PHYSICIAN'S he registror Sykesville, Maryland Edmund Lusthaus. M.D. NAME (Type) (7) 220 BURIAL CREMATION. 22b. DATE THEREOS 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) abod REMOVAL (Specify) Md. Baltimore 1959 Loudon Park 23. FUNERAL DIRECTOR'S SIGNATURE 24b. REGISTRAR'S SIGNATURE 24o, REC'D BY REGISTRAR

arthur S. House

PATE APR 1 3 '59

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wm. Cook, Inc. 1217 St. Paul St.

director

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certificate

death. erol 214-18-2857 John McHugh 1929 St. Paul St.

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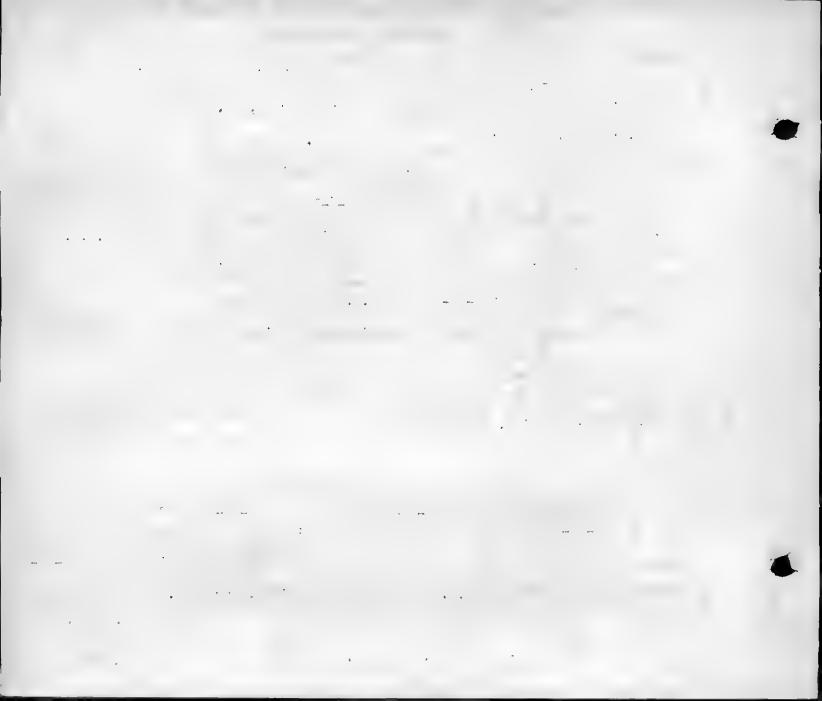
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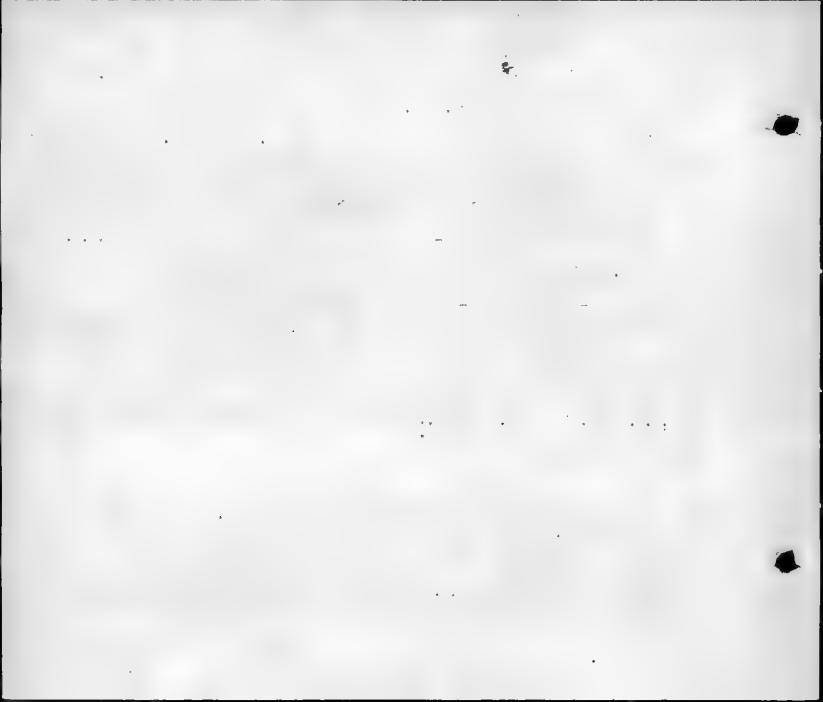
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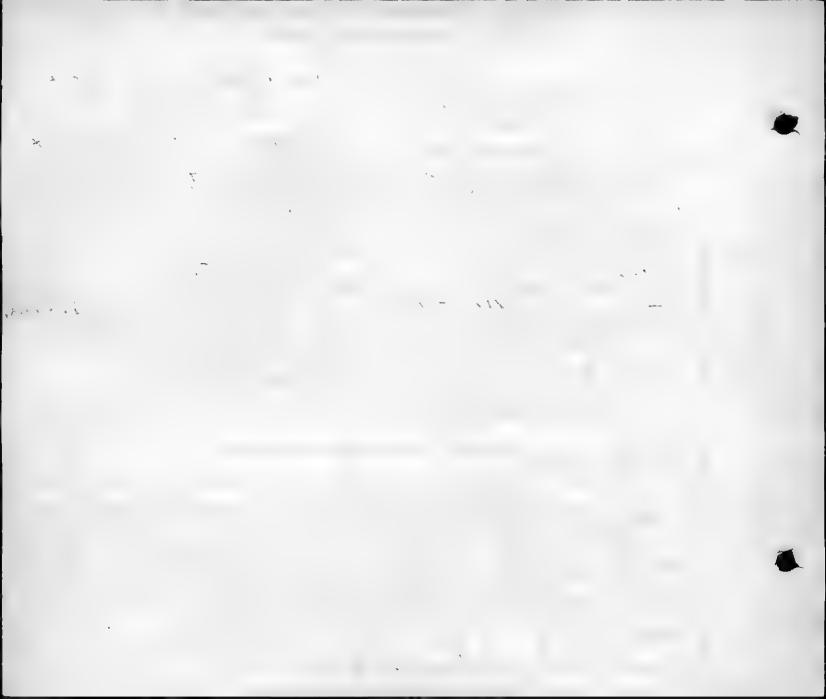
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04173

		418	4	CERTIFICATE OF DEATH						Reg. Dist. No.				
	PLACE OF DEATH	rroll	ě	MARYL	AND	2. USUAL RESID	Mary		d lived. If instit b. COUN		nce befo			
	b. CITY OR TOWN (IF RURAL and give near Sykesvill	outside carporate limi rest town) @	ts, write	Lyrs . 3mos .				utside carpo	rote limits, write L8	RURAL and	give ne	orest law	n)	
	d. NAME OF HOSPITA OR INSTITUTION Springfie	L (If not in hospital, o 1d State F	ive street	oddress) tal		d. STREET A		N. Cha	arles St	t.			FARM?	
3.	NAME OF DECEASED (Type or print)	Marga:		Middle Lewis		Marden		4. DATE OF DEATH	Apri	lanth	15) y	Year 19 59	
5. 9	Female	6 COLOR OF RACE White	7. MARR	IED NEVER MARRIED		8 date of Birth March 3	_	8	9. AGE (In year lest birthdoy	rs. IF UNDI Manths		IF UND Haurs	ER 24 HRS Min,	
100	during most of working Housewife	N (Give kind af wark ng life, even if retired	iona 10b.	KIND OF BUSINESS OR	INDUS	TRY 11. BIRTHPL	yland	ar fareign c	ountry)	12. 0		S.A.	COUNTRY	
13.	FATHER'S NAME					14. MOTHER'S	MAIDEN N	_				***		
	Frank J.					Colu	mbia	Troxe	ell Lewi	is				
15. (Yes	WAS DECEASED EVER	IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.		NFORMANT				ddress				
	No			-	5	pringfie	ld Ho	spita.	1 Record	ds				
		H [Enter only one co H WAS CAUSED BY: IMMEDIATE CAUSE (o		ne for (a), (b), and (c).] Arterioscle	rot	ic heart	dise	ase			ON	INTERVAL BETWEEN YEARS		
	Canditions, if any gave rise to im cause (a), stating the lying cause lost.	mediate DUE TO)											
CERTIFICATION	disease w	rith psych	otic							Eddings of	1 1(0)		AUTOPSY DRMED? NO [X]	
	200. ACCIDENT WAS OR CONTRIBUTING [(IF EITHER, NOTIFY A	UNDERLYING [] CAUSE OF DEATH SEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OC	CURREC) (Enter nature at	f injury in f	Part I ar Part	t II of item 18.)					
MEDICAL	20c. TIME OF INJURY Hour a.m. p. m.	Month, Day, Ye	While	NJURY OCCURRED 2 Not while at work	Oe. PLA	CE OF INJURY (I lary, street, office	Hame, farm bldg., etc.	20f. (City	ar town)		(County)		(State)	
21. 1 certify that I attended the deceased from January 4, 19 55, to April 15, 19 59, that I last saw the afive on April 14, 1959, and that death occurred at 2:20A M, from the causes and on the date st ADDRESS (Street, city or town, state) ACTUAL SIGNATURE 2d turned See M.D. Springfield State Hospital 4,										te stati	deceased ed abave ATE SIGNED 15/59			
22.	PHYSICIAN'S NAME (Type)	Edmund Lu			201/ -		cesvi]		aryland					
220	BURIAL CREMATION	4-18-5	9	Green M					lltimor			(Stot	te)	
100	funeral director's 1. Cook, In		St.	ADDRESS Paul Stree	t		24g. REC'I DATE AP	R 1 7 '5	PAR 246. RE	GISTRAR'S	GVATU	S.E.		



CERTIFICATE OF DEATH Reg. Dist. No. be filed with PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. COUNTY b. COUNTY MARYLAND akä c. LENGTH OF STAY IN 16 b. CITY OR TOWN (If obtside corporate limits, write c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) 19 KBS d NAME OF HOSPITAL (If not in hospital, give street address) . d. STREET ADDRESS e IS RESIDENCE ON A FARM? OR INSTITUTION LIBER YES NO NAME OF First Middle DATE Month Year DECEASED LONA MICHA DEATH (Type or print) 19 5. SEX 6. COLOR OR RACE 7. MARRIED R NEVER MARRIED 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months Days Hours DIVORCED [WIDOWED [7] 100. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) NEW WINDSOR 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME O. BANKARD DAVID 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16, SOCIAL SECURITY NO. Address 4USBAND MICHAE INTERVAL BETWEEN 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Conditions, if ony, which gove rise to immediate **DUE TO** caste (a), stating the underlying couse lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1101 19. WAS AUTOPSY PERFORMED? YES NO N 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f, (City or town) (County) (Stote) factory, street, office bldg., etc.) Hour a.m. While Not while of work of work 21. I certify that I attended the deceased from Fig. 20, 1957, that I lost saw the deceased and that death occurred at 3:347 M, from the causes and on the date stated above. olive on affect ACTUAL SIGNATURE DIR Ē P EDVESTABLE NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22¢, NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) UNION TOWN LUTHERN RURIAL 23. FUNERAL DIRECTOR'S SIGNATURE 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE · Cirching S. Hama VS A15 [4] DATE APR 2 2 '59 15M 9/55



			MARYL	AND STA	TE DEPARTA	MENT OF	HEALTH	I-BAL	IMORE, 1	8 ()	1 1 25	<i>(</i> 10
			4	186	CERTIFIC	ATE OF	DEATH	1		Reg. Di	417 st. No.	O
	1. [PLACE OF DEATH	Carroll		MARYLAND	2. USUAL I	residence (wh		lived. If institution b. COUNTY	oni Residen Garr		dmission)
		RURAL and give r	(If outside corporate limit searest lown)		GTH OF STAY IN 16		OR TOWN (IF o	utside corpor	ate limits, write R			lawn)
	<u> </u> -	Sykesvill NAME OF HOSPI	.1.8 TAL (If not in haspital, gi		rs.2mos.16d		Oakla ET ADDRESS	nd		117	(0.1)	S RESIDENCE ON A FARM?
1)	<u></u>	Springfi	eld State H				None	* ***********************************				S NO TO
	1	NAME OF DECEASED Type or print)	fin Georg		Middle Wilson	Montgo	werv.Sr	4. DATE OF DEATH	Mon Apri		Day	Yeor 19 59
	5. S	Ex Male	6. COLOR OR RACE		A company of the contract of t	B DATE OF	The second secon		9. AGE (In years last birthday)) YEAR IF	UNDER 24 HRS. ours Min.
	10o.	USUAL OCCUPATI	ON (Give kind of work d						73 yrs.	12. CIT	IZEN OF V	VHAT COUNTRY
	<u></u>	Miner	rking life, even if retired) Coal Soft	coal	mines		est Vir				U.S.A	•
	13.	FATHER'S NAME SAIMIOI M	lontgomery				ers maiden i rah Woo					
	15, [Yes		ER IN U. S. ARMED FORC		SECURITY NO 17.	INFORMANT			Add 1 Record			
		18 CAUSE OF DE	ATH [Enter only one cau								OMSET	AL BETWEEN
		2'6/1	IMMEDIATE CAUSE (a) DUE TO	Broi	nchopneumo	112	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~				Day	8
		Conditions, if a gove rise to cause (a), stoting lying cause last.	immediate DUE TO	Chre	onic pulmon	ary em	physema	and f	ibrosis		Yea	rs
0	CATION		HER SIGNIFICANT CONF OC. With dis hotic react	t of me ion. In	BUTING TO DEATH BUTING TO BEATH BUTING TO BUTING TO BUTING TO BEATH BUTING TO BEATH BUTING TO BUTING	TNOT RELATED OF NU CORIC I	trition racture	with righ	condition Gives to femur.	rain	116) 19. V 015 P	VAS AUTOPSY ERFORMED? S NO.
	CERTIFICAT	200 ACCIDENT W OR CONTRIBUTION (IF EITHER, NOTIF)	AS UNDERLYING G CAUSE OF DEATH MEDICAL EXAMINER)	206 DESCRIBE H	IOW INJURY OCCURR	ED (Enter notu	re of injury in I	Part I or Part	Il of item 18)			
	MEDICAL	20c. TIME OF INJU Haur a. m. p. m.	RY Manth, Day, Yea 19		lot while	LACE OF INJU actory, street, o	RY (Home, form office bldg., etc.	20f (City	or town)	(6	County)	(State)
		alive on_AT	hat I attended the		_, and that deat	h accurred	ot 9:30A	M, from ADDRESS (St	the causes o	ind on t		
,		ACTUAL SIGNATURE PHYSICIAN'S	guerr	re cec			ringfie			a was now you upto you you war	4	/17/59
- /	220	NAME (Type)	Agustin d	F 22c.	NAME OF CEMETERY	OR CREMATOR			ION (City, fown	or county)		(Stote)
		BEHOVE Precifi			irview C	emeter		near	Gorma	n, w	id.	
	23.	FUNERAL DIRECTO	exists a	<u> </u>	odress Oaklan	d, Md		D BY REGISTI		strar's si		
		16-1	- ye well					11 4 0 0		45,	10000	

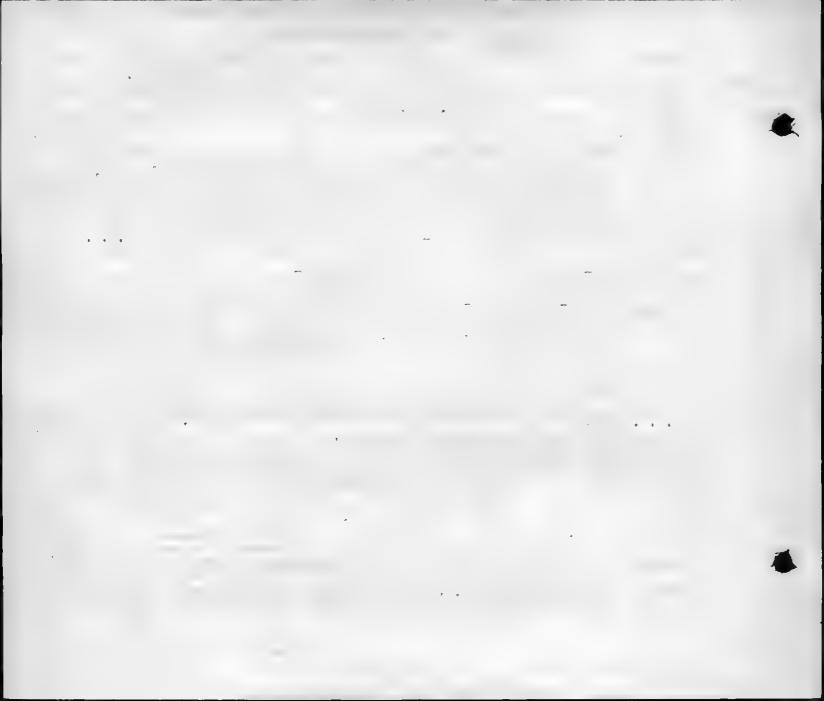


MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 Item 9, Film G241, CERTIFICATE OF DEATH Reg. Dist. No. director 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) filed 6. COUNTY b. COUNTY Carroll Maryland St. Mary 8 MARYLAND ero. b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)
Sykesville 2yrs.6mos.19days Abell d NAME OF HOSPITAL (If not in hospital, give street oddress)
OR INSTITUTION
Springfield State Hospital d. STREET ADDRESS . IS RESIDENCE ON A FARM? None YES NO .5 NAME OF Middle 4. DATE Month Year DECEASED 1959 April Mary Blanche Neumayer (Type or print) DEATH S. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Doys November 21. Female White DIVORCED [7] WIDOWED IX 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) U.S.A. Housewife Marvland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hames -Mary -15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address Springfield Hospital Records No IB. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ä ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) Arteriosclerotic heart disease vears **DUE TO** requires that ģ in on Conditions, if ony, which te has been signed to burial-transity permit remayol, and in any gove rise to immediate DUE TO cause (a), stating the underlying couse lost TIONS CONTRIBUTION OF DEATH BUT NOT SELATED TO THE FEBRUAR DISEASE COMPUTION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Moderately advanced pulmonary tuberculosis. YES NOTE 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, [Enter nature of injury in Part I or Part II of item 18] 20c. TIME OF INJURY Month. Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, | 20f (City or town) (County) (State) factory, street, office bldg., etc.) Hour o.m While Not while at work at work 21. I certify that I attended the deceased from September 1719 56 to April 6, 19.59 that I last saw the deceased , and that death occurred at 11:58PM, from the causes and an the date stated above. Ö ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Springfield Hospital FUNERAL DIN PHYSICIAN'S Edmund Lusthaus, M.D. Sykesville, Maryland NAME (Type) 220. BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, of county) pode REMOVAL (Specify) GULLI 0 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE

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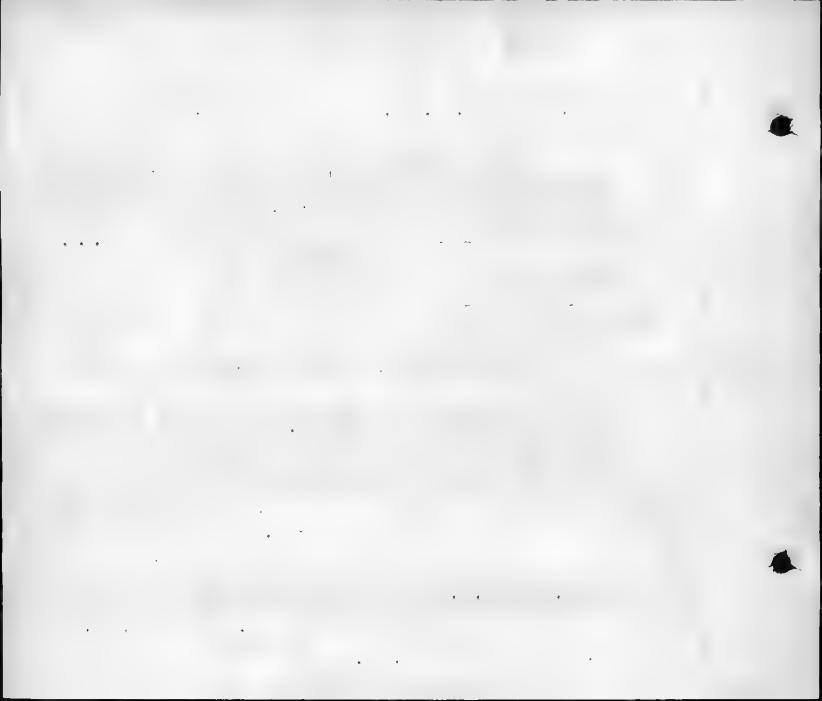
188	CERTIFICATE	OF [

		4.1					Keg. Dist. No.									
	1. PLACE OF DEATH o. COUNTY						2 USUAL RESIDENCE (Where deceased lived If institution: Resid					sidence	ence before admission)			
		Carroll			MARYL	AND							Alle	Llegany		
	5. CITY OR TOWN (RURAL and give n	If outside corporate li	nits, writ	c. LENG	TH OF STAY I	N 16	c. CITY OR	TOWN (If or	utside corpo	rote limit	s, write					
			ural) 27y.	2m. 23	2d.		Cumber	land	Rt.	, #	3	· , i	4	-23	
	d. NAME OF HOSPIT OR INSTITUTION	TAL (If not in hospital,	give stre	et oddress)			d. STREET	ADDRESS							RESIDEN	
	Springfi	Leld State	Ноз	oital			Ве	dford	Val	ley					5 🔼 N	
	3. NAME OF DECEASED		int		Middle		lo	est	4. DATE OF		M	onth		Doy	Year	
	(Type or print)		zie		Gert		0 t N	eal	DEATH		Aj	pril		8,	199	59
d	5. SEX	6. COLOR OR RAC	7. M	RRIED [] NI	EVER MARRIE	D 🔀	B. DATE OF BIR	ТН		9. AGE I	(In year	Mon		-	JNDER 24	
ł	Female	White		WED 🔲	DIVORCED	1	Novemb			7	8 yr	1. Mon	TITES Like	ירו גענ	DUTS	Min
	10a. USUAL OCCUPATION during most of wor	ON (Give kind of working life, even if retiri	done 10	% KIND OF	BUSINESS OF	INDUS	TRY 11. BIRTHE	LACE (Stole o	or foreign co	ountry)		12	. CITIZE	N OF W	HAT CO	UNTRYP
	Housey		<u> </u>	Dome	stic			ennsyl						U.S.	A.	
1	13. FATHER'S NAME						14 MOTHER	S MAIDEN N	AME							
/		Frederick						Harrie	t Las	hley						
	15. WAS DECEASED EVE	R IN U. S. ARMED FO	RCES? 1			17. It	NFORMANT				Ad	Idress				
	No	-		None	<u> </u>	<u></u>	Springf	ield S	tate	Hosp	ita	L Re	cord			
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Bronchopnamments													Days		
ı	4 of al. 1 DUE TO														_	
	Conditions, if ony, which (b) Arteriosclerotic cardiovascular Disease												Years			
	gave rise to immediate couse (a), stating the under-															
	lying couse last.		(c)													
١	FAST II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAR Schizophrenic reaction, Other and unspecified.										PART 1	PERFORMEDY				
	J						*			. () . ()	10.1			YE	S 🔲 N	· 1
	PART II, OTH SCHIZO	AS UNDERLYING TO CAUSE OF DEATH MEDICAL EXAMINER	205. U	ESCRIPE HOV	W INJURT OC	CURREL), (Enter noture	of Injury in P	off I of Pari	f II of (1e)	m 10 }					
	20c. TIME OF INJUR	Y Month, Doy, 1		. INJURY OC		20e PLA	CE OF INJURY	(Home, form,	20f (City	or tawn))		(Cou	nty)	((State)
	P. m.	19	Whi	rork of w	while ork	, 00	, , , , , , , , , , , , , , , , , , ,		'							
1	21. I certify th	at Lattended th	e dece	ased fram	July	1.	19_5	7. to AD	ril 8		1959	tho	t I las	t saw	the dec	ceosed
ı	alive on AI	ril 8.	, 19	59	and that	death	occurred at	8:55P	aM, fran	n the c	auses	and a	in the	date :	tated a	abave
1			1	On .	٥				DORESS (SI							SIGNED
ı	ACTUAL SIGNATURE	Kiter /	J	pla	hn	1	u.b. Sp:	ringfi	eld S	tate	Hos	pita	1		11/9	1/59
1	PHYSICIAN'S															
	NAME (Type)	Rita S. G.	lahn,	M. D.)		Sy.	kesvil	le, M	aryL	and					
	22a. BURIAL, CREMATIC REMOVAL (Specify)	N, 225. DATE THER	OF	22c. NA	ME OF CEME	TERY OF	CREMATORY		22d LOCAT						(Stote)	
	Buriai	4/11/	59		leasar	1t (Grove		Nr.							
	23. FUNERAL DIRECTOR		<i>a</i> 0		RESS	1			BY REGIST	- 1		GISTRAR"				
	Charles	L. Geor	ye	umbe	erland	1, N	Ad.	DATAPR	1 3 '59		ar	thung	8. K.	att A		

may be retained by the haspital or attending physician.

TO FUNERAL DIS JOR: After this certificate has been signed by the ottending physician and completely filled in by funeral director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shauld be filed with the registrar prior to burial, crematian, or remaval, and in any event within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4) 15M 9/55



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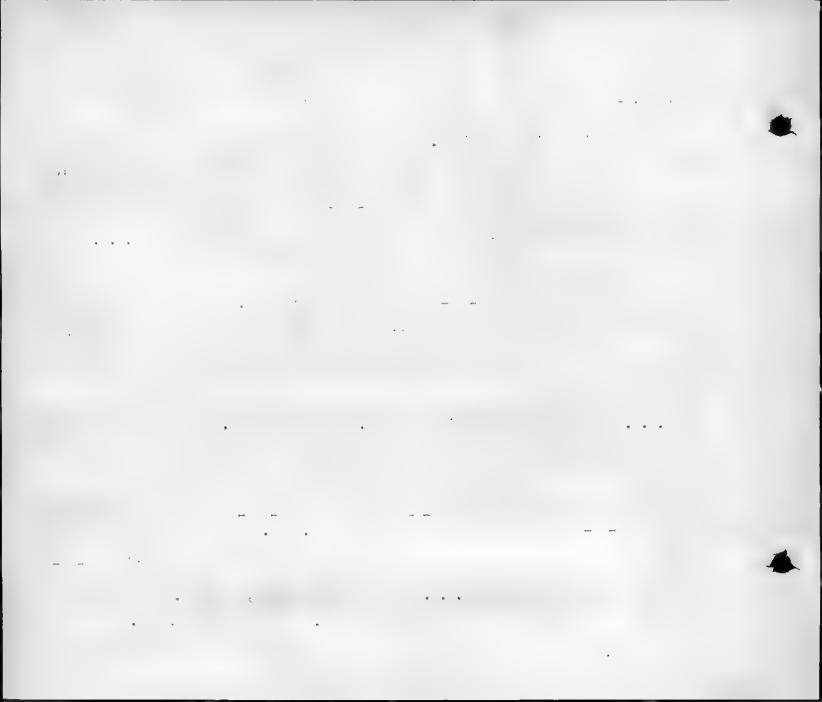
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death.



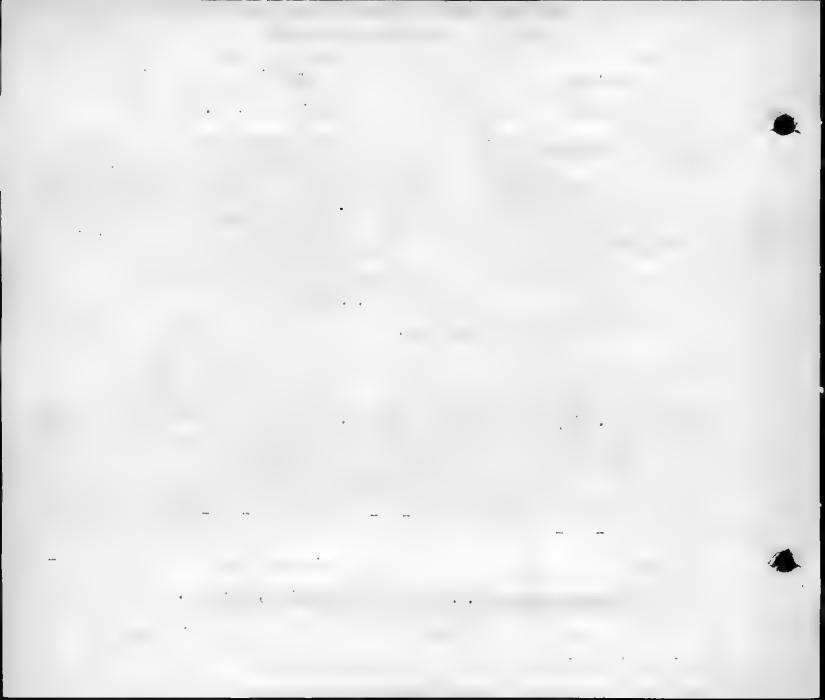
CERTIFICATE OF DEATH 4190 Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed If institutions Residence before admission) filed a COUNTY **b** COUNTY MARYLAND City Maryland Carroll b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) pland Baltimore 18. Md. Sykesville lo davs d NAME OF HOSPITAL (If not in haspital, give street oddress) OR INSTITUTION d STREET ADDRESS e. IS RESIDENCE ON A FARM? 3708 Greenmount Ave Springfield State Hospital YES NO NAME OF 4. DATE Middle Month DECEASED OF DEATH 18 1059 (Type or print) Kata Payton 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX 8. DATE OF BIRTH 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS Months Doys Jan. 29. 1863 WIDOWED TH DIVORCED [] 10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? naturalized USA housewife 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME John Lutwyche Elizabeth (unknown) 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address S.S. Hospital Records no 18 CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c)] INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (6) Bronchopneumonia DUE TO any Canditions, if any, which gave rise to immediate DUE TO couse (a), stating the underlying couse lost. burial-transit CBS assoc. With core brain arcer 10 per super and condition given in part 10 19. Was autopsy performed?

Arteriosclerotic cardiovascular disease YES NOTE 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18) certificate MEDICAL 20e. PLACE OF INJURY (Hame, form, 20f (City or lown) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED (County) (Stole) factory, street, office bldg., etc.) Hour a.m. Nat while al work of work 4 - 18 - 19 59, that I last saw the deceased 21. I certify that I attended the deceased fram.... , and that death accurred at 6:05 P.M. from the causes and on the date stated above. , 0 ADDRESS (Street, city or town, state) Springfield State Hospital shauld TO FUNERAL E PHYSICIAN'S Sykraville, Maryland. NAME [Type] Edward Tuethous M.D. 220. BURIAL, CREMATION, 226 DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) BUREMOVAL (Specify) Lorraine Mausoleum Woodlawn, At 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24g. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Vm. Cook. Inc., 1217 St. Paul Street Christing & House DATE APR 21 '59

death: Page

requires that



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 041814191 CERTIFICATE OF DEATH Rea. Dist. No. eral director. be filed with 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY Carroll b. COUNTY Montgomery Maryland MARYLAND b. CITY OR TOWN (If outside carporate limits, write c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest town)
Sykesville Syrs. 9mos. 28days Chevy Chase 15 d. NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE Springfield State Hospital ON A FARM? 139 E. Bradley Lane â YES NO pup NAME OF Middle 4. DATE 19⁵9 April Anne Rackstraw (Type or print) DEATH 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 83 yrs July 9, 1875 Female White Haurs WIDOWED [DIVORCED | 100. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or fareign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Teacher U.S.A. Michigan Supervisor of Art 13. FATHER'S NAME unending physician on please remave carbon within 72 murs after 14 MOTHER'S MAIDEN NAME Alfred G. Rackstraw Mary Jane Tate 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO. Address Springfield Hospital Records None Nο 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease **DUE TO** Canditions, if any, which gove rise to immediate DUE TO couse (a), slating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY Senile psychosis, paranoid type. PERFORMED? Fracture, right hip. YES 🗍 NO 🎉 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18) 20c. TIME OF INJURY Month, 20s. PLACE OF INJURY (Home, form, Day, Year 20d. INJURY OCCURRED 20f. (City or town) (County) (State) Hour factory, street, affice bldg, etc.) o. m. Not while of work of work 21. I certify that I attended the deceased from October 20, 1954, to April 21, 1959, that I last saw the deceased , and that death accurred at 4:33P M, from the causes and on the date stated above. alive on April 21 ADDRESS (Street, city or town, stota) Springfield State Hospital ACTUAL SIGNATURE FUNERAL I PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland 220 BURIAL, CREMATION, 22c NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVA (Specify) ON 23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240 REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE DATAPR 2 3 '59

death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4192 **CERTIFICATE OF DEATH** Reg. Dist. No PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a COUNTY o STATE b. COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town) RURAL and give nearest lawn) .. Tura d NAME OF HOSP.TAL (If not in haspital, give street address d. STREET ADDRESS OR INSTITUTION oucksul1 3. NAME OF First Middle 4. DATE DECEASED EARL (Type or print) DEATH 6. COLOR OR RACE 5. SEX 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years IF UNDER I YEAR IF UNDER 24 HRS lost birthday) Months DIVORCED WIDOWED [7] 10a USUAL OCCUPATION (Give kind of work dane 10b, KIND OF BUSINESS OR INDUSTRY 11, BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during-most of warking life, even if retired) TARM 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician that the death certificate IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INSORMANT Address altending ; 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART HOLLY WAS AUTOPSY 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II af item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or tawn) (County) factory, street, affice bldg, etc.) Hour a.m. While Nat while at wark - et wark -1957, that I last saw the deceased 21. I certify that I attended the deceased from... and that death accurred at 2:40 PM, from the causes and an the date stated above. alive and ADDRESS (Street, city or town, stple ACTUAL SIGNATURE should PHYSICIAN'S NAME (Type) 220 BURIAL CREMATION, 226, DATE THEREOF 22c NAME OF CEMETERY OR CREMATORY 22d JOCATION (City, lown, or county REMOVAL (Specify) 23.CFUNERAL DIRECTOR'S SIGNATUR **ADDRESS** 240. REC'D SY REGISTRAR 24b REGISTRAR'S SIGNATURE VS A15 (4) DATE MAY 1 .'59 Costner S. Kensed

15M 10/57

IS RESIDENCE

ON A FARM?

YES 🔀 NO 🗀

Year

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES 🗍 NO 🖺

> > (Stole)

DATE SIGNED

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Days

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r death! Page 4

may be retained. The hospital ar attending physician.

TO FUNEMAL DIR. JOR: After this certificate las leen signed by the atlanding pllysician and campletely filled in by invented director, page 3 shauld be detached for use as the burial-transit, milt. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, crematian, ar remaval, and in any event within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs aft

TO HOSPITAL OR

VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

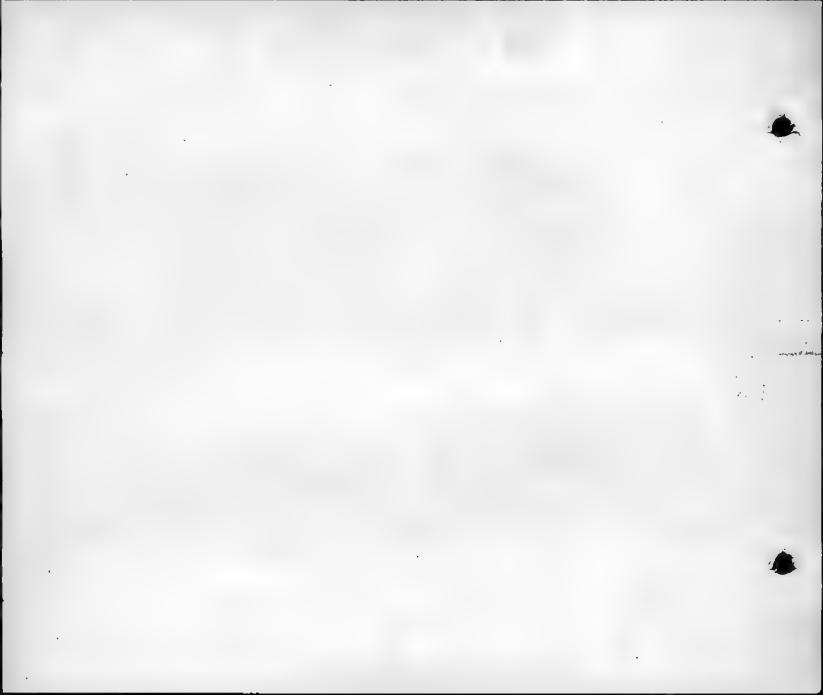
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CERTIFICATE OF DEATH

Reg. Dist. No.

	1. PLACE OF DEATH O. COUNTY	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) 9/STATE b. COMINTY
	b. CITY OR TOWN (If outside corporote timits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autiside corporate limits, write RURAL and give nearest town)
	RURAL and give nearest (pmp)	X Harris Day (=
	d. NAME OF ROSPITAL (Il not in hospital, give street oddress)	d STREET ADDRESS I B. IS RESIDENCE
	OR INSTITUTION E TAKE A LIVE	ON A FARM?
	251150011 31	DENEDUTY ST YES NO D
	3. NAME OF PICT Middle DECEASED	D. Last 4. DATE Month Day Year
	(Type or print) // // /= (*** *** *** *** *** *** *** *** *** *	MINEHART DEATH APRIL 12 1959
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8 DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthdoy) Months Doys Mours Min.
	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDL	STRY 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY?
	during most of working life, even if retired) HOUSE WIFE OWN HOME	MARVIAND IIIA
	13. FATHER'S NAME	14 MOTHER'S MAIDEN NAME
	ALBERT BUFFINGTON	FRANCES CIARY
		INFORMANT Address
	(Yes, no or unknown) (If yes, give wor or dates of service) NONE M	AYBELLE BAKER UNION BRIDGE MD
Ì	18 CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]	INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6)	They mummy is conserved to the
	DUE TO	in 1
	Conditions, if any, which) the CETAIN	oma of theolong Mecz
	gove rise to immediate couse (a), stating the under-	
	lying cause last. (c)	
,	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19, WAS AUTOPSY PERFORMED?
		YES NO
	FOR CONTRIBUTING □ CAUSE OF DEATH	D. (Enter nature of injury in Port I or Part II of item 18.)
		ACE OF INJURY (Home, form, 20f. (City or town) (County) (State)
	Hour a.m. 19 While Not while for work of work of work	
H	21. I certify that I attended the deceased from 4/3	19. 19. 10 19. 19. I last saw the deceased
1	alive on 1997, and that death	occurred at 9.15 AM, from the causes and on the date stated above.
	A LI TO	ADDRESS (Street, city or Joyrn, stote)
,	SIGNATURE MANAGEMENT	M.D. JAMIN Dullen GALS
	PHYSICIAN'S THE MESCIER	HALLON PRIDATE / NOW
1	NAME/Typel / O // //C.SCE/	UNICH BRIVGE /YD
1	220 BURIAL CREMATION, 22b. DATE THEREOF 22c NAME OF CEMETERY C	R CREMATORY 22d LOCATION (City, town, or county) (5tole)
	BUKIAL 7/13/59 MIPE CAL	EN CHKKOLL CO MD
	TUNERAL DIRECTOR'S SIGNATURE ADDRESS.	240. REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE
	DI Harmun Kous Muone)	CROWN PATERDR 1 4'59

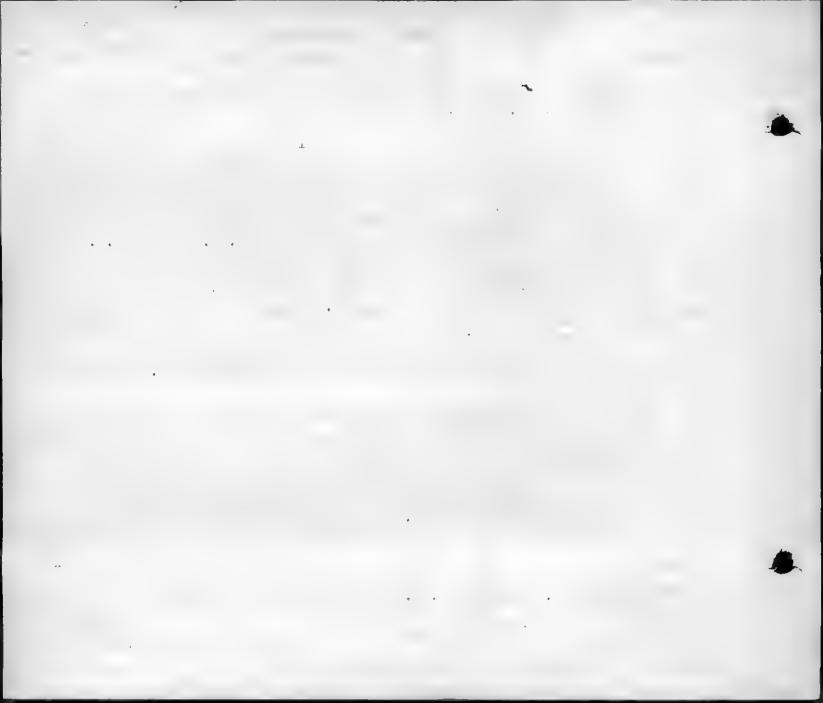


MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4194 **CERTIFICATE OF DEATH**

04184

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 Dist				2	

L.	PLACE OF DEATH o. COUNTY	arroll		MARY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY								
	b. CITY OR TOWN (IF	outside corporate lim	its, write	c. LENGTH OF STAY I	N 16	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town))
	RURAL and give ne	enryton,	Md.	7,497	5)								
Г	d. NAME OF HOSPITA			oddress)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM?			
L		Henryton	State	e Hospital		1116 Low S		Street			YES NO TO		
3.	NAME OF DECEASED	Fi	rst	Middle		la	st	4. DATE	Мо	nth .	Day	Υ	ear
L	(Type or print)	Joh:	n	Wesley	7	Robinso	n	OF DEATH	Apri	1	6	1	9 59
5.	SEX	6. COLOR OR RACE	7 MARR	IED NEVER MARRIE	D 🔲	B. DATE OF BIRT	H		9. AGE (In years last birthday)	IF UNDER T			
L	Male	Negro	WIDOWE	- Control of the Cont	town !	2-22-1			58 yrs		Doys H	ours	Min
100	USUAL OCCUPATIO	N (Give kind of working life, even if retired	done 10b.	KIND OF BUSINESS OF	NDUS	TRY 11, BIRTHP	LACE (State	or foreign co	ountry)	12. CITI	ZEN OF V	VHAT	COUNTRY
L	Labo:			Unknown		Park	csvill	le, N.	C.	1	U.S.	A	
13.	FATHER'S NAME					14 MOTHER'S	MAIDEN N	IAME					
L		Jasper .	Robin	son		Cha	alcey	Jones	3				
15.	WAS DECEASED EVER	IN U. S. ARMED FOI	CES? 16.	SOCIAL SECURITY NO.	17. IN	PORMANT			Add	lrwss.			
L	No			Unknown	J	ohn W.	Robin	son -	- Patien	t			
			ouse per lin	e for (o), (b), and (c).]				* 1 2*12-2811-4			INTERV.	NTERVAL BETWEEN	
	PART I. DEAT	H WAS CAUSED BY:	, Ca	rdiovascul	lar	insuffi	ciend	y			ONSET AND DEATH		
	Chapter is	DUE TO											
	Conditions, if ony, which) (b) Far adv. bilater						itary	pulmo	nary th	c.	20	ye	ars
	gave rise to immediate Course (a), stating the under-												
	lying couse lost. (c)												
CERTIFICATION	PART II, OTH	ER SIGNIFICANT CON	IDITIONS C	ONTRIBUTING TO DEA	TH BUT	NOT RELATED TO	O THE TERMIN	NAL DISEASI	E CONDITION GI	VEN IN PART		ERFOR	NO []
	20g ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OC	CURREC), (Enler noture o	of injury in P	ort I or Port	I II of item 18.)				
MEDICAL	20c. TIME OF INJURY Hour e. m. p. m.	Month, Day, Ye	White	NJURY OCCURRED Not while of work	20e PLA fac	CE OF INJURY (tory, street, offic	Home, form, a bldg , etc.	20f. (City	or town]	(Co	ounty)		(Stote)
	21. I certify the	at I attended the	decease	ed from Sept	. 26	. 19 38	3. ta #	pril	6 10 5	9that Lie	act cow	the c	deceased
	alive on Ap;			59_, and that									
	4	· h		na.	9-				reet, city or town,				TE SIGNED
	ACTUAL SIGNATURE	lyans Mili	/als	lary Mi.	0,	4 D		Henry	rton, Ma	rylan	d	4	-6-59
	PHYSICIAN'S	lgars M.	lacul	ans. M. D.		Не	enryto	n Sta	ate Hosp	ital			
220	BURIAL, CREMATION	N, 226. DATE THERE)F	22c. NAME OF CEME	TERY OF				IION (City, town,			(Stple)
13	REMOVAL (Specify)	4/10/5	9	MT. CAL	VA	14.		Cedar	HiLL.		MAT	d	
23.	FUNERAL DIRECTOR'S	Ch. id.		ADDRESS	7	1 4	24a. REC'D	BY REGIST	RAR 245 REG	STRAR'S SID	NATURE	-	
	G.O. WA	Ison If	-	1000 BYA	NL	y Hue	DAMPR	1 3 '59	Com				



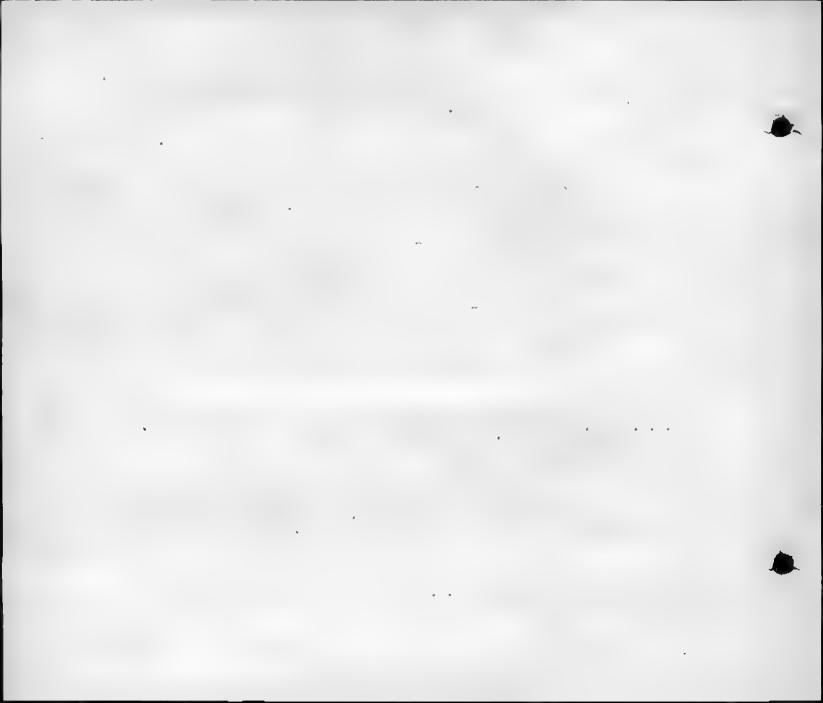
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4195 197 r death. may be retained the haspital at attending mystician. TO FUNERAL DIM DAR. After this certificate has been signed by the attending physician and completely fitted in by funeral page 3 shauld be detached for use as the burial-transit permit. Then please remove corbon papers. Pages 1 and 2 shauld be the registror prior to burial, cremation, or removal, and in any event within 72 hours ofter death. ATTINDING HYSICEN: The law requires that the Leath certificate be execu≡d within 24 haurs aft TO HOSPITAL OR

CERTIFICATE OF DEATH

04185

		77.00	0=111111			- I	log. Dist.	No.	
1.	PLACE OF DEATH COUNTY Carre	011	MARYLAND	2. USUAL RESIDENCE (V	where deceased li	ved. If institutions b. COUNTY		before odmiss	Hon)
	b. CITY OR TOWN (If autside RURAL and give nearest town Sykesville	carporate limits, wri wn)	timos . 12daya	c. City or town (if	outside carporet	D. /	AL and give	nearest town	1 1
	d. NAME OF HOSPITAL JIF no or INSTITUTION Springfield	of in hospitol, give str State Hosp	eet address) pital	d STREET ADDRESS	ark Heig	hts Ave.			SIDENCE A FARM? NOXE
3.	NAME OF DECEASED (Type or print)	Isadore	Middle Zelick	Sachs	4. DATE OF DEATH	April		Day 1,	Yeor 1959
5.	5.0	- J. P. J	ARRIED NEVER MARRIED DIVORCED DIVORCED	December 4,	-		UNDER I Y	EAR IF UND	ER 24 HRS. Min.
L	Sheet metal		06 KIND OF BUSINESS OR IND	Russia		itry)		n of what In icnow i	And And
/113	. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME				
L	Hyman Sachs			Frieda (oldburn				
15	WAS DECEASED EVER IN U. (If yes, give NO.	S. ARMED FORCES? war or dates of service)	16. SOCIAL SECURITY NO. 17	Springfield	Hospita	Address 1 Records			
			er line for (o). (b), and (c).] Arterioscleroti	ic heart disea	ase			interval be onset and Years	TWEEN
	Conditions, if any, while gove rise to immedia	to III	Generalized art	teriosclerosi	;			Years	
	cause (a), stating the underlying cause last.) (c)							
CERTIFICATION	C.B.S. assocat	opneumonia	NS CONTRIBUTING TO DEATH BU Dral arterioscle	erosis with p	AINALDISEASE C	reaction given	I IN PART 1	o) 19 WAS PERFO YES [AUTOPSY PRMED?
		RLYING [] SE OF DEATH L EXAMINER)	DESCRIBE HOW INJURY OCCURR	tED. (Enter nature of injury in	Port I or Port II	of item 18.)			
MEDICAL	20c. TIME OF INJURY Mont Hour e. m. p. m.	In W	d. INJURY OCCURRED 20e F hile Not while work at work	PLACE OF INJURY (Hame, for actory, street, office bldg., e	m, 20f (City or	fown)	(Cou	nly)	(Stale)
ı	21. I certify that I at alive on April		eased from December 259, and that deat	r 19, 19 58, 10 A) th occurred of 11:14	DPM, from I	he couses and	d on the		ed obove
	ACTUAL SIGNATURE LOTTURE	tru de	el Campo	ZM.D. Springf:		t, city or town, sto	rte)	4/	ATE SIGNED
			ampo, M.D.		lle, Mar				
22	PREMOVAL (Specify)	-3-59	me. NAME OF CEMETERY	TEVREW	22d LOCATIO	Felto	caunty)	Wo	٢
27	FUNERAL DIRECTOR'S SIGNA	No 21	00 Entar	Placa DATE	O BY REGISTRA	450	AR'S SIGNA	A	

VS A15 (4) 15M 9/55



04186

		41	96	(CERTIF	ICA	TE OF	DEATH	1			Reg. I	Dist. No).	
1. PLACE OF DI 6. COUNTY Carr					MARYL	AND	2. USUAL RES	_	era decapse		institutio		ence beli	ore admiss	ion)
b. CITY OR 1	TOWN (IF	outside corporate lim	its, write	c. LENGT	H OF STAY II	N 1b	c CITY OR	TOWN (If o	utside corpo	orate limits.	Write R	URAL on	d give ne	arest low	0) /
RURAL on	d give nec	rest town) Sykesville			7mo.50	- 11	, ,	kes√i/					ımor		300 66
d. NAME OF	HOSPITA	Liff not in hospital.	ive stre	at oddress)	Tarous	200	d. STREET		S STEEL VY	ULFALI		OL 1. U.	THIOT	e. IS RES	IDENCE
Spri	ngfi!	eld State	Hos	oital			194	ining th	: 61.8/9	(HAHA)	21467	444	Y /		FARM?
3 NAME OF	<u></u>	Fit	'st	·	Middle		10	11	4. DATE	HA NO	Mon	1 1 1 7 7	7		Year
(Type or prin	if)	Alb	ert		-	-	Sad	ler	OF DEATH		4		2	2	19 59
5. SEX		6. COLOR OR RACE	7. MA	RRIED NE	VER MARRIED	2 B	DATE OF BIRT	ГН		9. AGE (II	n years	2	7		ER 24 HRS.
Male		White		WED []	DIVORCED		/-	-/1891	L	68-	hdoy)	Months	Doys	Hours	Min.
100. USUAL OC	CUPATION	N (Give kind of working life, even if retired	done 10	b. KIND OF B	USINESS OR	INDUST	RY 11. SIRTHP	LACE (Stote	or foreign c	ountry)		12. (ITIZEN	OF WHAT	COUNTRY
none		ng me, even ir reilred	'	none			Mar	yland				U	SA		
13. FATHER'S N.	AME						14. MOTHER"	S MAIDEN N	IAME						
unkno	WIL						unkn	own							
15. WAS DECEA	SED EVER	IN U. S. ARMED FOR	CES? 1	6. SOCIAL SE	CURITY NO.	17. IN	FORMANT				Addi	e11			
unknow	n L	unknown		none			Springf	deld S	State	Hospi	tal	rec	ords		
		H [Enler anly one co	use per	line for (a), (b), and (<).]								INI	ERVAL BE	TWEEN
1 . 4. 4	•	H WAS CAUSED BY: IMMEDIATE CAUSE (c)]	Bi−late	ral pr	neum	onia							days	
450	U	DUE TO	•										m	ore t	han
Conditio gove ris		y, which) (b)]	Heart f	ailure	e du	e to ge	neral:	zed a	<u>rteri</u>	080	lero	sis	5 yea	rs .
couse (a),	stoting II														
lying cou) {c													
181 _		R SIGNIFICANT CON			***	TH BUT N	IOT RELATED TO	O THE TERMI	NAL DISEAS	E CONDITI	ON GIV	EN IN PA	ART 1(0)	PERFO	RMED?
		with men				CHOREC	(Enter noture	of Johnson to 6	lest Les Pre	a II al itam	19.1			YES [но 🏋
OR CONTR	BUTING I	CAUSE OF DEATH	100. 0		INJURY OC	CORRED.	fried uplace	DI INJURY IN I	GIT TO TO	I II OL HEIN	10)				
20c. TIME O	F INJURY	Month, Doy, Ye	Whi	INJURY OCC	rhile	20a. PLAI focti	E OF INJURY	(Home, farm ce bldg., etc.	20f. (City	y ar town)			(County))	(State)
	-				0 7 0	E	10	. 1	1-22		. E	3. , .			deceases
glive an	- 1	it I attended the					, У	, 10 <u>.</u>	P						
dilve di	43 - €4	1.4	}}	<i>*</i>	ana inai c	geath :	occurred at		/VI,TFOT ADDRESS (5				the do		ed above Ate signei
ACTUAL HITHATUM	<u>u</u>	Jally	14	wy	11	<i>i</i> .i	spr. Spr	ingfi	_ *				* * * * * * * * * *	4-22	
PHYSICIAN NAME (Typ	1'S W	alter Knor	p, 1	M.D.	1		Syk	esvill	Le, Ma	rylar	ıd				
220. BURIAL CE SEMOVAL		1, 226, DATE THEREO	of 5"5	9 22c NAA	NE OF CEMET	ERY OR	FILE		22d. LOCA	TION (City,	lown, c	or county	1	(State	0)
23 FUNERAL-DI	RECTOR'S	SIGNATURE (fol	ADDI	HESS P	Ele"	The !		PR 2.8	_ 1			SIGNATU S. H.		
1		7					7/		9 15 N U			CANALL T	4.19	AUA	

VIII A15 (4) 15M 9/55

Se 1 6 55 H from BC. on order of Separation; lety Curretie. 5/1/59 - ET.

			-	Tarent Land
Page 4		RAL DIR DR. After this certificate has been signed by the attending physician and sampletely filled in by funeral director.	led with	The state of
er death.		funeral	ruld be fi	
hours of te		in by	and 2 5ho	
ithin 24		ely filled	Coges 1	
secured w		TO LOS	popers.	forth.
ote be ea		ician and	e corbon	s ofter de
th certific		ding phys	se remov	n 72 hour
the dea		the attent	Then plec	vent with
uires tho		gned by	permit.	in any e
e law req	shysician.	is been si	1-tronsit	aval. and
JAN: The	tending p	ificate ho	the burio	Of remo
G PHYSIC	ital ar at	r this cert	for use as	crematian
MIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4	retaine the hospital or attending physician.	DR: After	letoched i	sister prior to burial, cremation, or removal, and in any event within 72 hours after death.
LOR A	aine	Dia.	uld be d	r prior to
YTA	ret	RA	sho	stra

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04187

	414								Reg. Dist	. No.		
1. PLACE OF DEATH o. COUNTY					2 USUAL RESID	DENCE (Wh	era decease	d lived. If institutio	n: Residence	before i	odmission)	
6. COUNIT	Carroll		MARYL	AND	o STATE	faryla	nd	b. COUNTY	Balti	more		
b. CITY OR TOWN (If outside corporate limit	s, write c	LENGTH OF STAY	N 16	c. CITY OR T	OWN (If a	utside corpo	rote limits, write Rt			I lown)	
RURAL and give in Svkest	rille (Rura)	1)	1 y. 14 d.		E	Baltim	ore	-	1			
d. NAME OF HOSPIT	TAL (If not in hospital, gi				d. STREET A			-		0.	S RESIDEN	NCE
or institution Spring	gfield State	Hosp	ital		3	123 N	. Eut	aw Street	;		ON A FAR 'ES 🗍 NO	
3. NAME OF	Fire	ıt	Middle		Los		4. DATE	Mant		Day	Year	
(Type or print)	Anr	na	Louis	38	Sche	pler	OF DEATH	Apri		17.		59
5. SEX	6. COLOR OR RACE				DATE OF BIRTH				IF UNDER 1	YEAR IF		
Female		WIDOWED			June 28	188	9	last birthday) 69 yrs.	Months [Days F	lours A	Mín,
10a USUAL OCCUPATIO	ON (Give kind of work d	lone 10b. KII	ND OF BUSINESS OF	INDUSTI				ountry)	12. CITIZ	EN OF	WHAT COL	UNTRY
Housewife	king life, aven if retired)				Ms	rylan	A		17	.S.A		
13. FATHER'S NAME					14. MOTHER'S			· · · · · · · · · · · · · · · · · · ·		PUPA		
	Charles Edwa	ard Hi	tchcock			Kate	Bart	o]				
15. WAS DECEASED EVE	R IN U. S. ARMED FORCE	CES? 16. SO		17. INF	ORMANT	210.00	DUL 0	Addre	215			
(Yes, no. or unknown)	(If yes, give war ar dates of se	rvice)		St	ringfie	eld St	ate H	ospital R	ecord			
18 CAUSE OF DEA	ATH [Enter only one cou	use per line	for (a), (b), and (c),1							INTERV	AL BETWE	ENI
	TH WAS CAUSED BY:	Dran	chopneumor	กริค						ONSET	AND DEA	ATH
1 1	MMEDIATE CAUSE (o), DUE TO	DION	rottobitemiot	ALC						, D	ays	
Sandings if a	an outlable	Anto	riosclero	Hio o	ondi orre	- Fuera	n dia	0000		70"	0.000	
Conditions, if o	mmediate (AI UC	I TOSCTEL O		aruitova	iocula	T. UTP	ease		3,	ears	
couse (o), stating lying cause lost.												
	J (c) TER SIGNIFICANT CONE		NITRIBUTING TO DEAT	THE BLIT NO	OT DELATED TO	THE TERMS	LAL DIFFAC	F COUNTION ON	TALIAL DART	1 10	ACAC ALITE	0054
Chron	lo brain sv	ndrome	e associate	ed wi	ith circ	culato	ry di	sturbance	Wit	hl	PERFORME	02
cerebral	arteriosela	anacic	S. with ps BE HOW INJURY OF	wehat	tic rear	etion.				Y	ES NC	5 Di
PART II. OTE Chroni Cerebral 200 ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	ZOU DESCRI	BE NOW HAJORT OC	COARED	(Chief horore of	r inqury in e	or i or ron	i ii or iiem ib.;				
		204 15111	URY OCCURRED	20- PIAC	E OF INJURY (F	Janua Smi	205 45%					
20c. TIME OF INJUR Hour a. m.	month, boy, rea	While _	Not while	focto	ry, street, office	bldg., etc.)	1207 (City	or rown)	(Ca	iunty)	(5	State)
			at work				<u> </u>					
21. I certify th	at 1 attended the	deceased										
alive anA	oril 17.	, 12.59	and that	death a	occurred at,	11:00	M, fran	n the causes a	nd on the	date	stated a	abave.
	mit-t.	. 7	Villiani				IDDRESS (SI	lreet, city or tawn, s	tale)		DATE S	SIGNED
SIGNATURE 7	Myanisi		WOV	м	D				**		1/17	1/59
PHYSICIAN'S			** D			- 1						
NAME (Type)	Konstantin					sykesv	lile,	Maryland	1			
220. BURIAL, CREMATIO REMOVAL (Specify)			22c NAME OF CEMET					TION (City, town, o			(Stote)	
Burial	4/20/19	59	Greenmo	unt	Cemete	ry	Balt	imore			yland	
23. THINERAL DIRECTOR		200	ADDRESS				BY REGIST		TRAR'S SIGN			
Ellsworth	Armacost	4600	Liberty H	ghts	.Ave.	DATE AP	K 2 1 '5	9 010	Chun S. 1	Statut.		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4198 CERTIFICATE OF DEATH

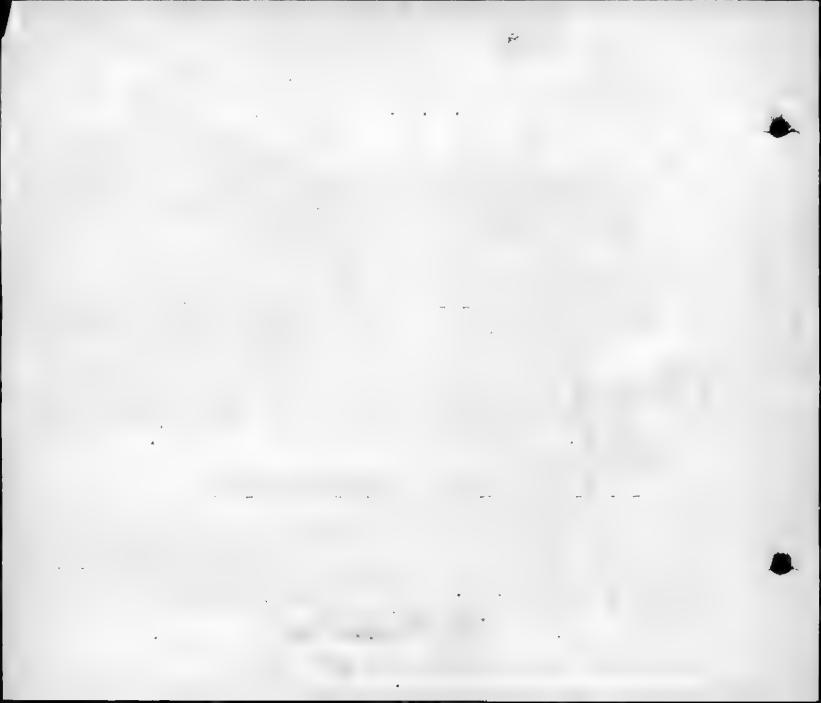
()4188 Reg. Dist. No.

- 1			_						Magi Die	1. 170.		
	1. PLACE OF DEATH COUNTY Carroll			MARYL		usual RESIDENCE (W	/here decease	d lived. If instituti b. COUNTY WAST	on Residence	e before	odmissi	on)
ĺ	b. CITY OR TOWN (If RURAL and give ne	outside corporate limi	ls, wnle	c. LENGTH OF STAY II	N 16	c. CITY OR TOWN (IF	outside corpe				est fown	
- [(Rural)	Sykesyille		2yr.limo.5da	a.	Hagersto	. כתעום	A	1	-0.		
2-	d. NAME OF HOSPITA	AL (If not in hospital, g	ive street	oddress)		d. STREET ADDRESS				IS RESIDENCE ON A FARM?		
7		field Stat				Washingt	on Cor	unty Home		YES NO		
	3. NAME OF DECEASED	Fir	d	Middle		Last	4. DATE	Mor	rffi	Day	۲	001
ì	(Type or print)	Benjamin		Ernest		Shirk	DEATH)2		15	1	9 59
-[5. SEX	6. COLOR OR RACE	7. MARE	RIED NEVER MARRIED	D. 1	DATE OF BIRTH		9. AGE {In years	IF UNDER			
ı	Male	White	WIDOWI	ED DIVORCED		10-28-75		83 yrs	Months	Days	Haurs	Min
	10a. USUAL OCCUPATIO	N (Give kind of work ing life, even if retired	lone 10b.	KIND OF BUSINESS OR	INDUSTR	1 11. BIRTHPLACE (Slate	or foreign c	ountry)	12 CITI	ZEN OF	WHAT	COUNTRY?
	Teacher			none		Maryland	1		USA	1		
	13. FATHER'S NAME					MOTHER'S MAIDEN	NAME					
-1	unknown					unknown						
ı	15. WAS DECEASED EVER	IN U. S. ARMED FOR		SOCIAL SECURITY NO.	17, INFO	RMANT		Add	ress			
- [unknown	unknown		170-12-3056		Springfield	State	Hospita	1 Reco	rds		
- [18. CAUSE OF DEAT	TH [Enter anly one co	use per lii	ne far (a), (b), and (c).]						INTER	VAL BET	WEEN
1	PART I. DEAT	H WAS CAUSED BY:	B	i-lateral Pr	reumo	nia				OVE	day	BEATH
-1	490 X	DUE TO										
	Conditions, if on											
-	gove rise to in couse (o), stoting I	medio E										
1	lying couse lost.) (c	·									
H	Z Chronico	HELTAS THPER	DITIONS (ONTRIBUTING TO DEAT	HAUT NO	TRELATED TO THE TERM	INAL DISEAS	E-CONDITION G	EN IN PART	1(a) 19.	WAS A	UTOPSY
	J or nutri	tion, with	sen	ile brain di	iseas	e_with psy	chotic	reaction	n Eron	,	res 🔲	NO 🌁
ı	200. ACCIDENT WAS	UNDERLYING	20b. DES	ile brain di	CURRED (Enfer nature of injury in	Port I ar Par	t # of item 18.)				
1		MEDICAL EXAMINER)		_ tag tag								
- [20c TIME OF INJURY Hour a.m.	Manth, Doy, Yea			Oe PLACE	OF INJURY (Home, far, street, affice bldg., et	m, 20f. (City	or fown)	(C	punly)		(State)
	Hour a.m	19	While at war	Not while	-							
	21. I certify the	at I attended the	deceas	ed from]2-12)	. 12.56 to	1,_15	1950	.that I k	ast sov	v the o	decensed
-	alive on	b=15		9, and that o								
		latto	1.7	100				treel, city or town,				TE SIGNED
Л	ACTUAL SIGNATURE	vally	W	us yus	M.D	Springfie	ld Sta	te Hospi	tal)	1-15	-59
	PHYSICIAN'S	701 . 70									II 444,44.	
Į	NAME (Type)	Walter Kn	opp,	M.D.		Sykesvill	e. Mar	wland				
	220 BURIA CREMATION REMOVAD (Specify)	1, 226. DATE THEREO	9	7/ 17 SELL	ANTON C	TORKTORY)	728 LOCA	TION (City, lown,	or county)	1.1	(Stote	}
1	23. FUNERAL DIRECTOR'S	FEIGNATURE /	/	SDOTESS /	11/1	Zid. REC	D BY REGIST	IRAR 24b. REGI	STRAR'S SIG	NATURE		
	Frank	DY Mars	dl	Willemit	1/28	VIIIV	PB 2 1					
E	1 1/1/1/1	1 - JULAN	46	1 Marie	100		BULL		7	10	-	

funeral director, should be filed with ir death. Page 4 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of may be retain.

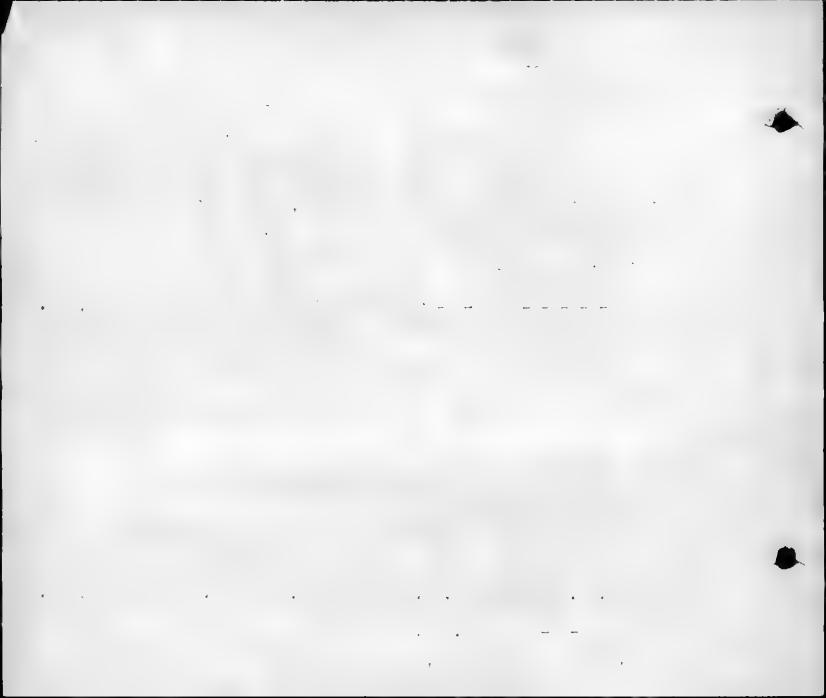
1. FUNERAL DISCORDER: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages I and 2 site registrar prior to burial, crematian, or removal, and in any event within 72 hours after death. TO HOSPITAL OR may be retain TO FUNERAL DI VS A15 (4) 15M 9/55

M



			413	93		CERTIF	CATE	OF	DEAT	Н					[0]
o.	ACE OF DEATH COUNTY	Ca	rrol	1		MARYL	- 11 /	JSUAL RE	Mary	Where decease	sed lived	l. If institution b. COUNTY	oni Residenc	oll	admission)
ъ.	CITY OR TOWN RURAL ond give PUP 8	(If outside concest town)	rporote limi tmin	ster				c. CITY O		,			•	ive near	sst town)
d			haspital, g	ive street a		urg	1			War	[1e]	Lāsbu	rg	"	IS RESIDENCE ON A FARM? YES NO X
D	ECEASED			-		Middle Newto	n S			4. DATE OF DEAT			ith	2 ^{Doy}	1,59
5. SE	x Male						B. DA			1870	9. AC	By thday) yrs.			F UNDER 24 HRS Hours Min.
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		ER IN U. S. A	ARMED FOR or or dotes of so	ecvice)					Shock	e y I	R 5			ster	, Md.
	PART I. DE	EATH WAS CA	NUSED BY: E CAUSE (o	a	rel	ral L			ge ,	hyp	airt	Lusen		ONSE	VAL BETWEEN T AND DEATH
	Conditions, if gave rise to casse (a), stating	ony, which immediate g the <u>under-</u>	(b)	7	Hleg f	eart	List (4h	Du	pho	le.	der				
CATION			CANT CON		ONTRIBU	TING TO DEAT	TH BUT NOT	RELATED	TO THE TER	MINAL DISEA	SE CON	IDITION GIV	EN IN PART		WAS AUTOPSY PERFORMED? YES NO 12
	200. ACCIDENT W DR CONTR BUTIN IF EITHER, NOTIF	AS UNDERLY G [] CAUSE Y MEDICAL E	ING [] OF DEATH XAMINER)	20b. DESC	RIBE HO	W INJURY OC	CURRED. (En	ter noture	of injury i	n Part 1 or Pa	ort II of	item 18.)			
MEDICAL	Hour a.m.		Doy, Yes	While	Not	while	factory,	OF INJURY street, off	Y (Home, fo fice bldg., e	rm, 20f. (Ci	ly or la	wn]	(C	ounly)	(State)
- 1		4 4 4	40.00					, 19 urred o	, la	M, fro	ım the	causes a	ind an th		
		w=	<u>C</u> 9	E dare	elk		M.D.		103	E 1.	Mar	m /v.	ratu		
ا	NAME (Type)		/					:	3 E.					ster	
	BURIAL, CREMATI REMOVAL (Specify REMOVAL	oi I			ì	ME OF CEMET						City, town, o		r A 4	(Stote)
	UNERAL DIRECTO		21-5	9		O.O.F	Ceme	ter	_	C.D BA KECI:		aven	TRAR'S SIG		
Notice of the second se	5. N. Dil (T)	RURAL ond give RURAL OND give d. NAME OF HOSP OR INSTITUTION I. NAME OF DECEASED I. LEAD OCCUPAT during most of wo TOLIT 3. FATHER'S NAME S. WAS DECEASED EV Yes, no, or unknown TO 1B. CAUSE OF DE PART I. DE 42 2 C Conditions, if gave rise to catte (o), stating lying couse lost PART II. O 20c. TIME OF INJU Hour o. m. P. m. 21. I certify to alive on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	b. CITY OR TOWN (If outside co RURAL and give aparest lown) TUP 31 We S d. NAME OF HOSPITAL (If not it OR INSTITUTION S . NAME OF DECEASED (Type or print) SEX Male Do. USUAL OCCUPATION (Give kin during most of working life, ever retired Bar 3. FATHER'S NAME W111 S. WAS DECEASED EVER IN U. S. A Yes, no, or unknown) IB. CAUSE OF DEATH [Enter PART I. DEATH WAS CALL Conditions, if ony, which gave rise to immediate cate (o), steting the underlying couse lost. PART II. OTHER SIGNIFI 200. ACCIDENT WAS UNDERLY OR CONTR BUTING [] CAUSE (IF EITHER, NOTIFY MEDICAL E 201. TIME OF INJURY Month, Hour o. m. p. m. 21. I certify that I attendative on ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) W C	D. COUNTY CAPPOL b. CITY OR TOWN (if outside corporate liming RURAL and give nearest fown) FUFBL Westmin d. NAME OF HOSPITAL (if not in hospital, gor Institution) J. NAME OF DECEASED (Type or print) SEX ALL OG. LOLOR OR RACE White OG. USUAL OCCUPATION (give kind of work during most of working life, even if returned during most of working life, even if returned the returned barber 3. FATHER'S NAME WILLIAM S. WAS DECEASED EVER IN U. S. ARMED FOR (if yas, give wer or date of the part of the par	b. CITY OR TOWN (If outside corporate limits, write RURAL ond give perest Lown) TUTAL WESTMINSTER d. NAME OF HOSPITAL (If not in haspital, give street of OR INSTITUTION) SEX WARTIE. 1. SEX A. COLOR OR RACE THOUSE THE WIDOWE WIDOWE WIDOWE WIDOWE WIDOWE TO LITTED THOUSE THE WIDOWE WORK WIDOWE	b. 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CITY OR TOWN (if outside corporote limits, write RURAL and give correct from in hospital, give street oddress) OR INSTITUTION D. CITY OR TOWN (if outside corporote limits, write RURAL and give correct from in hospital, give street oddress) OR INSTITUTION D. CITY OR TOWN (if outside corporote limits, write RURAL and give correct from in hospital, give street oddress) OR INSTITUTION D. ASTREE NAME A. STREET ADDRESS R 5 WARFIELDSBURG March D. ASTREE SHADES Warfieldsburg D. ASTREE SHADES Now Modele Now Modele WIDOWED D. OVORCED D. ASTREE SHADES Now Modele Now Modele WIDOWED D. OVORCED D. ASTREE SHADES Now Modele Now M	PRACE OF DEATH O. COUNTY Carroll Carroll

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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	o. COUNTY	arroll		MARYL	AND	2. USUAL RESIDENCE O. STATE Mar	r (whe	re deceased lived	If institution b. COUNTY	n, Residenc	e before o	odmission	.)
	RURAL and give no	f outside corporate limi orest fawn) lenryton	la, write	c. LENGTH OF STAY II	1	e. CITY OR TOWN	tim		mits, write RU	_	ve neares	t town)	
	d. NAME OF HOSPIT OR INSTITUTION Heni	At (If not in hospitol, gryton State	Hos]	oddress) Dital		d. STREET ADDRE		. Gilmor	e Stre	et	1	S RESIDE	ARM?
3.	NAME OF DECEASED (Type or print)	Fir Euge	ne	Middle		Simpson		4. DATE OF DEATH	April	i	19	Yeo 19	5 9
5.	Male Male	la. COLOR OR RACE Negro	7. MARE	NEVER MARRIED DIVORCED	_	September	13,	1907 los	E (In years birthday) 51 yrs.	Months		UNDER :	24 HRS Min.
100	usual occupation during most of work Unemp.	N (Give kind of work a ing life, even if retired LOYED	done 10b.	KIND OF BUSINESS OR	INDUS	North	Slote o	r foreign country) olina			S.		DUNTRY?
13.	FATHER'S NAME					14. MOTHER'S MAIL	DEN NA	AME					
1	Mark Sin	npson				Nealy	Bat	tey					
15. (Ye		R IN U. S. ARMED FOR lit yes, give wor or dates of s		SOCIAL SECURITY NO	17. IN	Provid	lent	Hospita	Addre				
	18. CAUSE OF DEA	TH [Enter only one co	use per li	ne for (a), (b), and (c).]								AL BETW	
	PART I. DEA	TH WAS CAUSED BY: IMMEDIATE CAUSE (o	, (Cardiovascu	lar	accident					ONSET	AND DE	EATH
	×	DUE TO											
	Conditions, if a	ny, which) (b	,	Syphilis an	d ex	ctensives s	supp	urating	bed so	ores			
	gave rise to in cause (a), stating lying cause last.	nmediate (Far advance	d bi	lateral pu	lmo	nary tul	erculo	śis			
CERTIFICATION	PART II. OTH	IER SIGNIFICANT CON	DITIONS C	CONTRIBUTING TO DEAT	TH BUT I	NOT RELATED TO THE T	TERMIN	IAL DISEASE CON	DITION GIVE	N IN PART	, i	WAS AUT	AED?
	20a. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OC	CURRED	. (Enler nature of injur	ry in Po	ert f or Port II of	item 18)		1		
MEDICAL	20c. TIME OF INJURY Hour e. m. p. m.	Y Month, Day, Yea	While	NJURY OCCURRED Not while to at work	loe. PLA foci	CE OF INJURY IHome, tory, street, affice bldg	, farm, -, etc)	20f. (City or to	vn}	{Co	ounly)		(State)
	21. I certify the alive on Apri	at I attended the 11 19,	deceas	ed from Januar	y 6 death	, 19 <u>.59</u> , to occurred at <u>9</u> =3	JOA.	M, fram the	causes an	nd on the	ast saw e date	the de	eceased above
	ACTUAL SIGNATURE	gars M.	Mac	ulary		A.D	_	nryton,	ily ar tawn, si	iore)		DATE	19-59
		dgars M. Ma		ns, M.D.		Henr	yto	n State	Hospit	al, F	lenry	ton,	Md.
Z	OREMOVAL (Specify)	N, 226 DATE THEREO	22	22c. NAME OF CEMET	ERY OR	CREMATORY	. 2	2d. LOCATION I	City, lawn, or	county)		(Stole)	
23.	FUNERAL DIRECTOR	SIGNATURE	1	ADDRESS /		/ 7		BY REGISTRAR	24b. REGIST	RAR'S SIGI			

VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04191**CERTIFICATE OF DEATH** 4207 Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. COUNTY o. STATE D. C. **b.** COUNTY Carroll MARYLAND death. b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest fown) Mt. Airy Washington 3 davs d NAME OF HOSPITAL (If not in hospital, give street address) d STREET ADDRESS . IS RESIDENCE OR INSTITUTION Route #3 6707 14th St.. N.W. YES NO K NAME OF DECEASED First 4. DATE Middle Lost Month Day Yeor OF DEATH **JEFFERSON** PAHI. SMITH APRIL 19 59 (Type or print) oges 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH IF UNDER I YEAR IF UNDER 24 HRS 9 AGE [In years lost birthdoy) Months Doys 2/23/03 MALE WHITE WIDOWED | DIVORCED popoles. cample 100. USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Superintendent of Press Room Mt. Airy, Maryland U.S.A. Newspaper 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME David W. Smith Alice V. Day 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address NO NO 578-97-7116 Mrs. Emma A. Smith. 6707 14th St., N.W. Water the Bone, D. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)] ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5 monerally DUE TO Conditions, if any, which gove rise to immediate DUE TO couse (o), stoling the underlying couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS ALTOPSY PERFORMED? YES NO | 20a. ACCIDENT WAS UNDERLYING A OR CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stole) Hour o.m. factory, street, office bldg., etc.) While Not while of work of work 21. I certify that I attended the deceased from Language, 19.56, to 22 martin 19.54 that I last saw the deceased 7 Program, 19 59, and that death accurred at 7:15PM, from the causes and an the date stated above. ADDRESS (Street, city or lown, stote) DATE SIGNED ACTUAL SIGNATURE shoold Seruch T. Kimble PHYSICIAN'S NAME (Type) 350 220. BURIAL, CREMATION, 22b. DATE THEREOF 22d LOCATION (City, town, or county) 22c. NAME OF CEMETERY OR CREMATORY BUR LAL (Specify) 4/6/59 PINE GROVE CEMETERY MT. AIRY. MARYLAND **ADDRESS** 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE INC. arthur & Kraug SILVER SPRING, MD. DAMPR 6



Item 20 Film MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE Reg. Dist. No. EALTH DEPT. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. COUNTY Health, 6. COUNTY Carroll MARYLAND Maryland Carroll. b. CITY OR TOWN (It pulside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown Keymar d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDEN E ON A FARM? tained I YES 🔲 NO 📋 Route 0 £ 3. NAME OF First Middle 4. DATE Month Year DECEASED (Type or print) Clifford DEATH Lerov Stansburw 19 59 April 20 5. SEX 7. MARRIED | NEVER MARRIED | B. DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS. aut birthday) Months Days Hours Min Male White WIDOWED [7] DIVORCED [7] 20 August 12,1938 100. USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Farmer Maryland II.S.A 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME William J. Stansbury Elizabeth Wilson 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (If yes, give war or dates of service) Mr. William J. Stansbury, Keymar, Md. R #1 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEET ONSET AND GEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** buriol-trai Offi Conditions, if any, which gave rise to immediate cause DHE TO (a), stating the underlying Exominer couse fast. Ð PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(d) 19, WAS AUTOPS PERFORMED? NO [20g. EXTERNAL CAUSE WAS PRIMARY OF OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED (Enler nature of injury in Part I or Part II of item 18.) Motorcycle accident 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f. (City or fawn) While Not while foctory, street, office bldg., etc.) 20c. TIME OF INJURY Month, Day, Year (County) (State) n Taneytown Carroll Md. 19 59 of work of of work Place of death 21. I certify that I took charge of the remains described above, held an Autopsy []. Inspection K. Inquiry 7 and in my for Juded DIRECTOR: opinion death resulted from: Natural causes Accident 📉 Suicide . Homicide , Undetermined monner designated ACTUAL DATE SIGNED CHIEF MEDICAL EXAMINER SIGNATURE xecute the cilibration is should be f ASSISTANT MEDICAL EXAMINER [7] L EXAMINER'S NAME Hypel DEPUTY MEDICAL EXAMINE NO 270. BURIAL CREMATION, 226 DATE THEREOF 27c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL (Specify) 40 Burial Kevsville Cemetery Keysville, Maryland ADDRESS 23 FUNDERAL DIRECTOR'S SIGNATURE 24g. REC'D BY REGISTRAN 246, REGISTRAR'S SIGNATURE VS. A15ME C.O. Fuss & Son Cirthur & Hraus DATE APR 2 2 '59 5M 2/57 Tanevtown. Maryland



TO HOSPITAL OR may be retaine

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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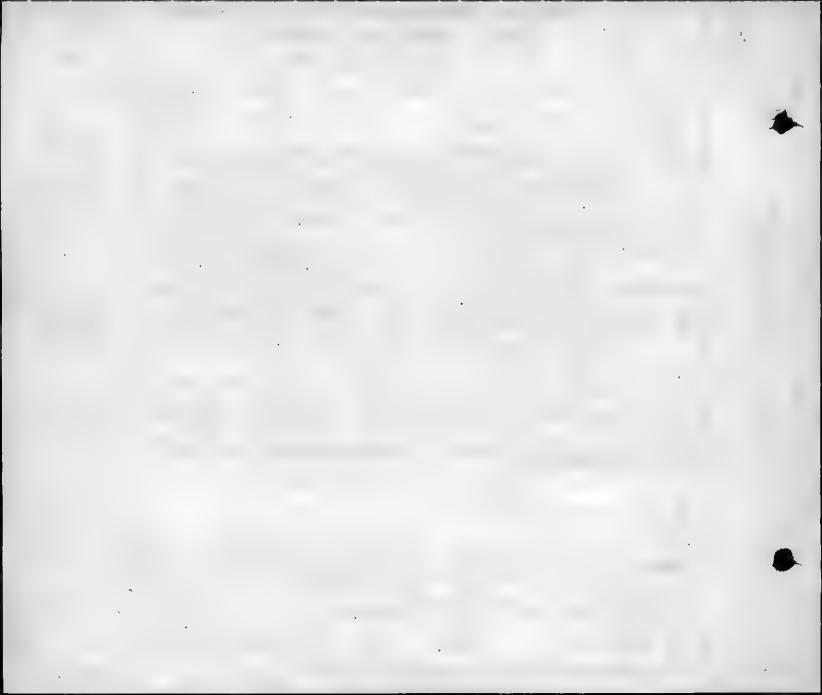
CERTIFICATE OF DEATH

()4193 Reg. Dist. No.

	PLACE OF DEATH	arroll		MARYLAN	- 11	O STATE	Maryl		lived. If instit b. COUN	TY		edmission)
	RURAL and give ne	outside corporate limit prest town)	s, write	LIMOS . 26days	- 11		own (If or		rote limits, writ	RURAL and	give near	eif fown)
-	Sykesvill	L (If not in hospital, g	ve street o			d. STREET A		24				# IS RESIDENCE
	Springine	ld State H	ospit	al			N. Bo	uldin	St.			IS RESIDENCE ON A FARM? YES NO TO
3.	NAME OF DECEASED	Fire		Middle		Lost		4. DATE	A	lonth	Day	Year
ļ	(Type or print)	Char	Les	Albert	t	Stene	gel	DEATH	Ap	ril	16,	1959
5.	Male Male	6 COLOR OR RACE White	7 MARR WIDOWE	IED NEVER MARRIED [DIVORCED	_ [DATE OF BIRTH Septemb		,1890	9. AGE (In year lost birthdo)			Hours Min
100	USUAL OCCUPATIO	N (Give kind of work ong life, even if retired)	lone 10b.	KIND OF BUSINESS OR IN	NDUSTR	Y 11. BIRTHPL	ACE (Stole o	r foreign co	untry)	12. C	ITIZEN OF	WHAT COUNTRY?
L	Cabinet m						yland				I.S.A	
13.	FATHER'S NAME					14. MOTHER'S						
L	Charles S						known					
15. Ye		IN U. S. ARMED FOR		SOCIAL SECURITY NO		DRMANT				ddress		
L	NO	-	131	3-05-1779	Sp	ringfie	ld Ho	spita	1 Recor	ds		
		-		e for (a), (b), and (c)]							INTER	TAND DEATH
		H WAS CAUSED BY IMMEDIATE CAUSE (o	Met	astatic card	cino	ma of 1	ung				Me	onths
	163X	DUE TO										
	Conditions, if on gove rise to in									* -		
	couse (o), stating t											
,	lying couse lost.) (c			D. 17						1	
CERTIFICATION	C.B.S.ass psychotic	oc.with wireaction.	ther	CONTRIBUTING TO DEATH	unk	OWN OF	unce	rtain	Cause	with	RT 1(o) 19	PERFORMED? YES NO T
CERTIFI	200 ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	S UNDERLYING [] [] CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY OCCU	JRRED. (Enler nature of	injury in P	ort I or Port	Il of item 18.)			
MEDICAL	20c TIME OF INJURY Hour o.m.	Month, Day, Yea	While	Not while	PLACE factor	OF INJURY II	fome, form, bldg , etc.)	20f (City	or town)		(County)	(State)
3	p. m.			of work	0	2	A .		· -			
	A-001	it lattended the	decease	od from Novembe								
	alive on ADI	11 109	_, 122	Z, and that de	ath a	ccurred at.					the date	e stated above.
	ACTUAL SIGNATURE	- to	-01	I Carre be	,	Spri		,	reet, city or lov spital	vn, store)		DATE SIGNED
	SIGNATURE	Jours out	Care	- Court	M.[118170	20 110	DITUAL			4/10/29
L	PHYSICIAN'S NAME (Type)	Agustin de	LCamp	o, M.D.		Syke	svill	e, Mar	ryland_			
220	BURIAL, CREMATION	1, 226. DATE THEREO	F	22c NAME OF CEMETER				-	ION (City, tow			(State)
_		4/20/59		Holy Rede					<u>ltimo</u> :			
23.	FUNERAL DIRECTOR'S	SIGN HOTEN-	3000	EADDRESS altir	nor	St.		BY REGIST		GISTRAR S S		
							DATE A	PR 2 0	22	- commy	A. / 15.4.	~~~



1-/-			MARYLAND STATE DEPARTMENT OF HEA	LTH—BALTIMORE, 18	
X	>		4204 CERTIFICATE OF DEA	ATH () 4194 Reg. Dist. No.	
Page director)	1, 0	PLACE OF DEATH CONTY COUNTY MARYLAND 2. USUAL RESIDENCE O. STATE	(Where deceased lived. If institution Residence before admission b. COUNTY	on)
death.		7	b. City OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN RURAL and give nearest town)	IN 11 spride, corporate limits write RUBAL and give nearest town)
by in	X		d. NAME OF HOSPITAL (If hot in hospital, give street address) d. STREET ADDRE	ESS (1). The least section on a yes in	FARM?
24 hau lled in			NAME OF DECEASED (Type or print) The rate of Table 1	4. DATE Month Day Y	ear 9
d within	١	5,,5	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH WIDOWED DIVORCED	9. AGE (In years IF UNDER 1 YEAR IF UNDER loss buthday) 9. AGE (In years loss IF UNDER 1 YEAR IF UNDER loss IF UN	R 24 HRS. Min,
od comp		100	JUSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. ERTHPLACE) Addring most of working life, even if relired)	(State or foreign county) 12. CITIZEN OF WHAT	COUNTRY?
cian and cian and carban s after de		13.	FATHER'S NAME I Strewig 14 MOTHER'S MAIL	DEN NAME	
certific ng physi remaw 72 hour		15. (Yes	WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT / (If yes, give wor or dates of service)	C Theral Knich sto	, h
attendiin n please t within			18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Courant Zhura	interval BET ONSET AND	DEATH
that the by the it. The ty even!			Conditions, if any, which) DUE TO		
requires ian, in signed nsit perm and in ar			gove rise to immediate cause (a), stating the under-		
physicia as been ial-trans	٧	CATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS A PERFOT	RMED?
IAN: The ending ficate hathe burnar ar rem		CERTIFI	20a. ACCIDENT WAS UNDERLYING ACCOUNTED. (Enter nature of injution of contributing Cause of Death (IF Either, Notify Medical examiner)	ry in Part II ar Part II af item 18.)	
PHYSIC ol or att his certi use as ematian		MEDICAL	20c. TIME OF INJURY Month, Day, Year While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat while of wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to the total p. m. 19 20d. INJURY OCCURRED While Nat wark to	e, form, 20f. (City or town) (County) g., etc.)	(Stole)
NDING e hospita After t ched far urial, cr			21. I certify that I attended the deceased from 1949, to alive on assistable 1859, and that death occurred at 43	o april 17, 1959, that I last saw the G	
be deto			ACTUAL SIGNATURE WIN Fround M.D. Man		TE SIGNED
OSPITAL OR De retained JNERAL DIR! 19 3 should be registrar priar	- 1		PHYSICIAN'S WHFOATD M.P. A	Marchester, ud	
may be O FUNEI page 3 the regit	~ M	220	PEMOVAL TSpecify) 226. DATE THEREOF . 22c NAME OF CEMETERY OF CREMATORY .	224 LOCATION (City, towar/or county) (State	aint
VS A15 (4) 15M 9/55	1	23.	FUNGRAL DIRECTOR'S SIGNATURE BUCKER & PRESENTE & DATE	o. REC'D BY REGISTRAR 246. REGISTRAR'S SIGNATURE Orthog S. House	



VS A15 (4) 15M 9/55

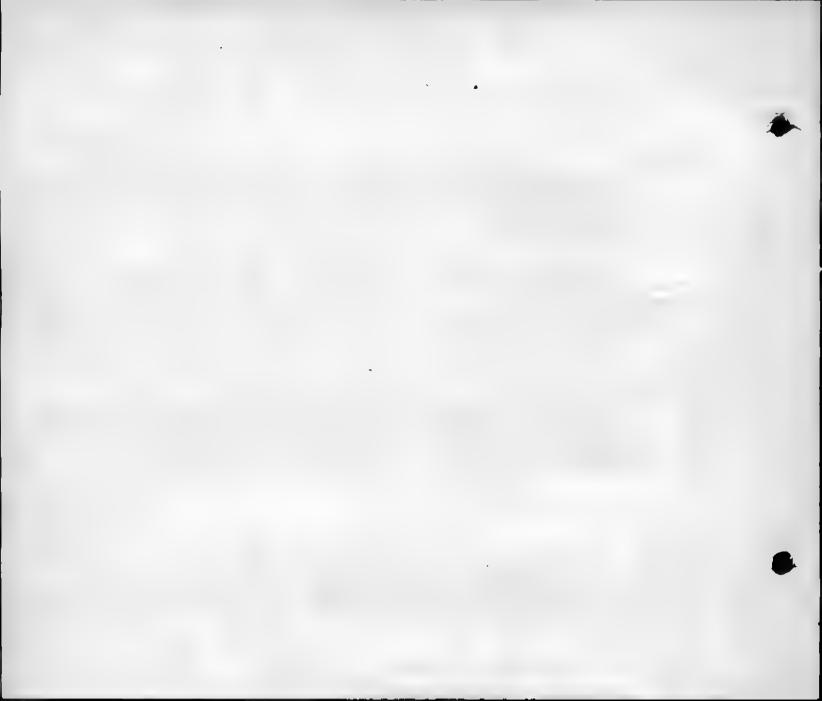
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H

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04195

	4205 CERTIFIC	ATE OF DEATH	Reg. Dist. No.
	PLACE OF DEATH O. COUNTY CARROLL MARYLAND	2 USUAL RESIDENCE (Where deceared fived. If	institution: Residence before admission) OUNTY
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Signature of the state of t	C. CITY OR TOWN (If outside corporate limits,	write RURAL and give nearest town)
	d NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION PRINCE IS D STATE HOSPITAL	d STREET ADDRESS	STREET TYES NO ET
	NAME OF First Middle DECEASED (Type or print) TRANK BAKE		Month Day Year 4 9 1959
	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH 9. AGE (1) lost bir	n years IF UNDER 1 YEAR IF UNDER 24 HRS Inday) Months Days Hours Min.
1	DO. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR IND during most of working life even it retired. TATIONARY ENGINEER BALTO GAS 4 EL	March 1	12. CITIZEN OF WHAT COUNTRY?
1	WILLIAM TAWNEY	14 MOTHER'S MAIDEN NAME	
1	S. WAS DECEASED EVER IN U. 5 ARMED FORCES? 16. SOCIAL SECURITY NO. 17. 181. 100 or unknown) (If yes, give wor or doted of service) VES 12 -07 -6207	H. KLAATSCA M.D	SPRINGFIELD HOSE
	IMMEDIATE CAUSE (8)	ASCULAR ACCIDEN	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if ony, which gove rise to immediate couse (o), stoling the under-fying cause last. DUE TO (b) 17 YPERTE	NSIVE CARDIOVASCULA	R DISEASE years
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE TERMINAL DISEASE CONDITI	ION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?, YES NOTE:
		ED. (Enter nature of injury in Port I or Part II of item	18}
	20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. F Hour o. m. While Not while of work 0 of work	LACE OF INJURY (Home, farm, 20f (City or town) octory, street, affice bldg., etc.)	(County) (State)
		h accurred at 9°00 P. M. from the ca	
ı	ACTUAL Kein & Klaatup	MD. SPRING FIELD STI	
	PHYSICIAN'S HEINZ H. KLAATSCH	SYKESVILLE /	
_		RE CEMETER BALTIN	MORE MARYLAND
1	Wm Gook-Blist In. 6009 Harl	1 0 1	6. REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 4206 Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY Carroll MARYLAND Marvland ť b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest lown) Oaklev Henryton d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS OR INSTITUTION Renryton State Hospital none 3. NAME OF Middle 4. DATE Lost Month DECEASED April Albert John Thomas (Type or print) DEATH 5. SEX 6. COLOR OR RACE AGE (In years IF UNDER I YEAR IF UNDER 24 HRS. MARRIED IX NEVER MARRIED 8. DATE OF BIRTH lost birthdoy) Male DIVORCED [May 31, 1897 Negro WIDOWED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (Stole or foreign country) during most of working life, even if relired) Hurry, Maryland Farm 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Annie Thomas Young Hilliary Thomas 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address Rosanna Thomas-Oakley, St. Mary's Co., Md. Yes War I None CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY Cardiovascular insufficiency IMMEDIATE CAUSE (o) **DUE TO** Cerebrovascular accident Conditions, if ony, which gove rise to immediate **DUE TO** couse (a), stating the under-Moderately advanced pulmonary tuberculosis lying couse lost CATION PAIT II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY 200. ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 205. DESCRIBE HOW INJURY OCCURRED, (Enter noture of injury in Port I or Port II of item 18.) 20s. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Doy, Year 20d INJURY OCCURRED 20f. (City or town) foctory, street, office bldg., etc.) Hour o.m. Not while ot work ot work 21. I certify that I attended the deceased from Feb. 27. 1959 that I last saw the deceosed 10, Apr. ____, and that death occurred at 3:15 AM, from the couses and an the date stated above. ADDRESS (Street, city or lown, stole) ACTUAL SIGNATURE Henryton, Maryland Ø PHYSICIAN'S Edgars M. Macudans, M. D. Henryton State Hospital, Henryton, Md. 220 BURIAL CREMAT ON.

FUNER/ page EMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DENS BATE 4/10/59

Calling S. House

(County)

04196

St. Mary's Co.

10.

Dovs

e. IS RESIDENCE ON A FARM? YES 🔀 NO

Hours

INTERVAL BETWEEN ONSET AND DEATH

> PERFORMED? YES NO

> > (Stole)

DATE SIGNED

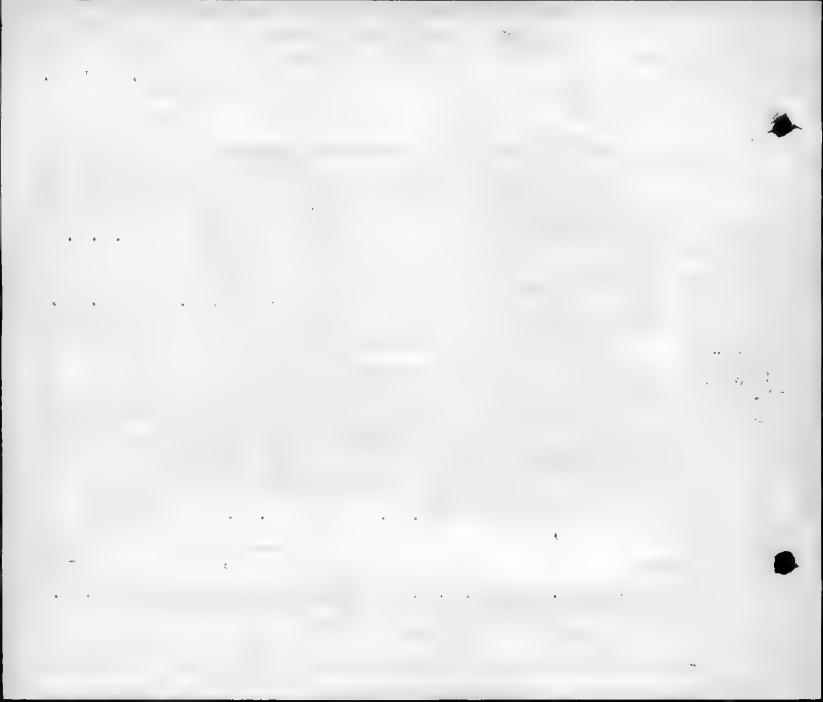
4-10-59

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

159

VS A15 (4) 15M 9/55

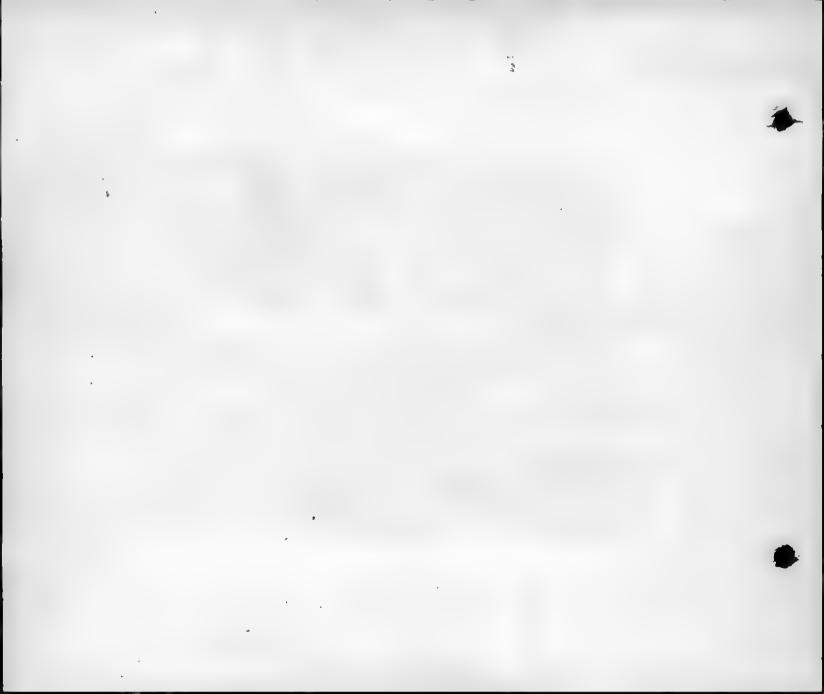


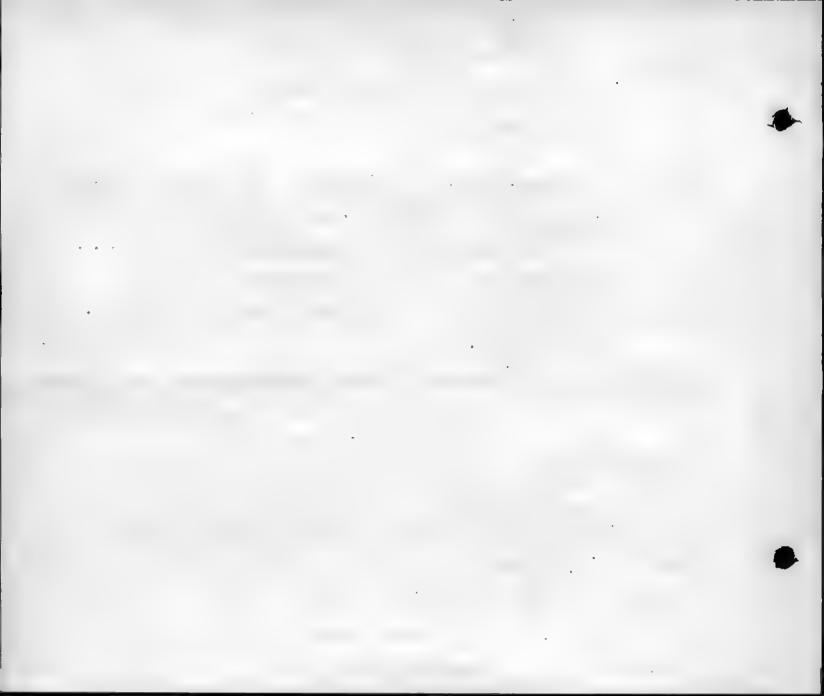
V\$ A15 (4) 15M 10/57

	MARYLAND	STATE DEPARTM	ENT OF HEALTH—BALTIMORE	, 18
	4207	CERTIFICA	ATE OF DEATH	R
2 -			2 USUAL RESIDENCE (Where deceased lived. If inst	itution:

04197

	Reg. Dist. 140.
PLACE OF DEATH	2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY (1)
b. CITY OR TOWN (If outside corporate limits, write c, LENGTH OF STAY IN 1b	MARYLAND CARROLL
PURAL and give negrest tryin)	INION BRIDGE
d NAME OF HOSPITAL (If not in haspital, give street address) OR INSTRUCTION	d. STREET ADDRESS e. IS RESIDENCE
RUZHU	RURAL ON A FARM?
3. NAME OF DECEASED (Type or print) First Middle	TUCKER DEATH APRIL 195
5. SEX 6 COLOR OR RACE 7. MARRIED TOEVER MARRIED	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YE R IF UNDER 24 HRS
F COL WIDOWED DIVORCED	JUNE 22-1891 67 m
100 USUAL OCCUPATION (Give kind of work dane) 10b. KIND OF BUSINESS OR IND during most of working life, even if retired)	DUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY
HOUSEWIFE OWN HOME	14. MOTHER'S MAIDEN NAME
LUTHER HAYES	BECKY MURDOCK
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17	INFORMANT Address RURH
NO NONE	TOHN T TUCKER UNION BRIDGE MU
18. CAUSE OF DEATH [Enter only one couse pen line for (o), (b), and (c)]	INTERVAL BETWEEN ONSETJAND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (o)	My occurrence 1/2 mg
Conditions, if ony, which }	sulla has best and all the
gove rise to immediate	The second
couse (a), stoting the <u>under</u> lying couse last. (c)	cho-cases (
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BY	UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
	YES NO (
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	RED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. Hour a. m, P. m. 19 While Not while of work of wark	PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, affice bldg, etc.)
₹ p. m. 19 of wark at wark	
21. I certify that I oftended the deceased from 1959 and that dece	195 (that I last saw the decease
olive on that dea	ADDRESS (Street, city or town, state) ADDRESS (Street, city or town, state)
SIGNATURE CORPORATION OF THE SIGNATURE CORPOR	200 15 Render are, 7/5/59
PHYSICIAN'S DHE, REESEVYI	Keng heatminuter and
220. BURIAL, CREMATION, 226. DATE THEREOF 220 NAME OF CEMETERY	OR CREMATORY Z2d LOCATION (City, town, or county) (State)
BURIAL 9/10/37 MI OL	IVE FREDERICK CO. MD
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	240 REC'D BY REGISTRAR 246 REGISTRAR'S SIGNATURE
NN MUNICULIAND MUCH EX	LAGE DATE





MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 4209 **CERTIFICATE OF DEATH** meral director, d be filed with

04199 Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)								
Carroll	MARYLAND	o. STATE Marylar	b. COUNTY	Howard						
b. CITY OR TOWN (If outside corporate limits, write	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outsi	de corporate limits, write RUR/	AL and give nearest town)						
RURAL and give nearest town) Sykesville	5yrs.6mos.12d	ays Relibies	Jessup	12 x v						
d. NAME OF HOSPITAL (If not in hospital, give street OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE						
Springfield State Hospi	ital	Guilford	i Road	ON A FARM? YES NO I						
3. NAME OF First	Middle	Lost 4.	DATE Month	Day Year						
(Type or print) Marge	aret	Voorhees	28, 19 59							
S. SEX 6. COLOR OR RACE 7. MARI	RIED NEVER MARRIED	B. DATE OF BIRTH		UNDER 1 YEAR IF UNDER 24 HRS.						
Female White widow	ED DIVORCED	April 25, 1870	O lost birthdoy)	lonths Doys Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done 10b, during most of working life, even if retired)	KIND OF BUSINESS OR INDUS	STRY 11, BIRTHPLACE (State or I	oreign country)	12 CITIZEN OF WHAT COUNTRY?						
None	TOTL	Maryland		U.S.A.						
13. FATHER'S NAME	. /	14 MOTHER'S MAIDEN NAM	E	5						
linknown John 1	16th heer	Unknown //	Uty 8 -	1						
IS. WAS DECEASEDEVER IN U. S. ARMED FORCES? To.	SOCIAL SECURITY NO.	NFORMANT	Address	-						
No -	TA-35-12	Springfield Ho	spital Records							
18. CAUSE OF DEATH [Enter only one couse per li	ne for (o), (b), and (c).]			INTERVAL BETWEEN						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) BY										
491× DUE TO				20072						
Conditions, if ony, which) (b)										
gove rise to immediate DUE TO										
lying couse lost. (c)		_								
C.B.S. assoc. with circ.d.	CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINA	DISEASE COND TION GIVEN	IN PART 1(a) 19. WAS AUTOPSY						
C.B.S. assoc. with circ.d. psychotic reaction	race amron cerer	Tar ar veriosci	CIOSTS WIOIT	YES NO						
OR CONTRIBUTING CAUSE OF DEATH	CRIBE HOW INJURY OCCURRE	D. (Enter noture of injury in Port	Lor Port II of Item 18.)							
20c. TIME OF INJURY Month, Doy, Year 20d. I Haur o. m. 19 of world work	fa.	ACE OF INJURY (Home, farm, 1): story, street, office bldg., etc.)	20f. (City or town)	(County) (State)						
	rk ot work									
21. I certify that I attended the decease	ed fram October 2	20, ₁₉ 54 _{ta} Apr	il 28, ₁₉ 59, _{the}	at I last saw the deceased						
alive an April 27,	29 and that death	accurred at 7:04A M	fram the causes and	on the date stated above.						
51. 14	. #		DRESS (Street, city or town, sto	A A CALL						
SIGNATURE Column of u	311-au-	M.D. Springfiel	d State Hospit	al 4/28/59						
PHYSICIAN'S Tedamend Treathers	- W D	Codes and The	Manual and	2"						
NAME (Type) Edmund Lusthau	B, M.D.	Sykesville	, maryiano							
220. BLRIAL, CREMATION, 226 DATE THEREOF REMOVAL (Specify)	22c. NAME OF CEMETERY O	R CREMATORY 22	LOCATION ICITY town, or ?	ounty) (State)						
13uning 3-2-31	GRAMMOBEZ	6	Meghelistol.	n, in , il.						
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D B	Y REGISTRAR 246 REGISTR	AR'S SIGNATURE						
faction of a things	C. 77.65046C.	1714 - ONAY 1	150 0.71	9 4						

TO HOSPITAL OR TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nature may be retained. The hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, crematian, ar remaval, and in any event within 12-hops, after death.

death. Page 4

VS A1S (4) 1SM 9/SB



VS A15 (4) 15M 9/55

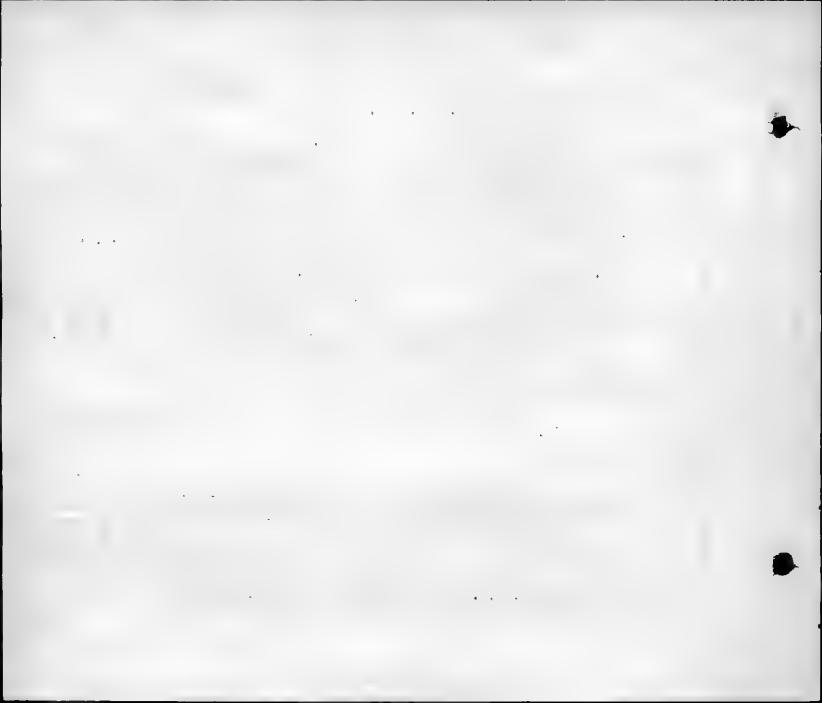
15

MARYLAND	STATE DEPARTMENT	OF	HEALTH-BALTIMORE,	18
4210	CERTIFICATE	OF	DEATH	

04260

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY Washington									
b. CITY OR TOWN (If or RURAL and give neare	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)														
(Rural) Syk	• Hagerstown														
d NAME OF HOSPITAL						d STREET A						•	IS RES	DENCE FARM?	
Springfield State Hospital 36 S. Potomac Street											YES 🔲	NO 🔼			
3. NAME OF First Middle Lost DECEASED								4. DATE Month					٦	rear	
(Type or print) Randolph J					Walker		DEATH		4		14	1	19 59		
S. SEX 6. COLOR OR RACE 7 MARRIED 7 NEVER MARRIED						8 DATE OF BIRT	Н		9. AGE (In	years	Months [Y		
Male	White	WIDOWE	0 🗆	DIVORCED		2-21-18	389		70	yrs.	MONTHS	Poys	Hours	Min.	
100. USUAL OCCUPATION during most of working	(Give kind of work de	one 10b.	KIND OF B	USINESS OR	INDU	TRY 11. BIRTHPL	ACE (State)	or foreign c	ountry)					COUNTRY	
Dentist			unk	nown		Flor	rida				U	.S.	A .		
13. FATHER'S NAME						14 MOTHER'S	MAIDEN N	IAME							
Charles P.	Walker					Lucy	G. Hu	ırd							
15 WAS DECEASED EVER IN	U. S. ARMED FORCE		SOCIAL SEC	URITY NO.	17. J	VFORMANT				Addr	ess				
unknown	unknown	*****	none		S	pringfie	ald St	ate H	ospita	al F	lecord	S			
18 CAUSE OF DEATH	Enter only one cou	se per lir	ne far (a), (l	b), and (c)]									VAL BE		
PART I DEATH	PART : DEATH WAS CAUSED BY Minutes ONSET AND DEATH Minutes														
<i>f</i>	DUE TO														
Conditions, if ony,	ons, if ony, which (b)														
couse (o), stating the	couse (o), stoting the under-														
	lying couse lost. (c).														
Schizo	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? Schizophrenia, hobephrenic type YES PA NO 1											RMED?			
200 ACCIDENT WAS I	·) /Enter polyce o	f miney in P	Port Lat Pari	t II of item 1	B 1			LES FO	МОП	
OR CONTRIBUTING (IF EITHER, NOTIFY ME															
20c. TIME OF INJURY	Month, Doy, Yeor		VJURY OCC			ACE OF INJURY I			or town)		{Co	only)		(Stote)	
P. m.	19	While of work	k 🔲 🛅 😽 👸	t while factory, street, office bldg., etc.)											
21. I certify that	21. I certify that I attended the deceased from 8-1955, 19, to 1-11, 19.59, that I last saw the deceased														
alive on	4	. 19	59	and that a	death	accurred at	3:10	"M., fran	n the cau	ses a	nd an the	e date	state	d above	
/	10/	11.			,			ADDRESS (SI	treet, city or	town, s	lote)		DA	TE SIGNED	
ACTUAL SIGNATURE	acity !	M	0)1	, /		M.D S	pringf	field	State	Hos	pital		4-14	-59	
PHYSICIAN'S			1/4	11					_	_					
NAME (Type) Wa	lter Knop), M	.U.	-/		Sy	kesvil	lle, M	laryla:	nd					
220. BURIAL, CREMATION, REMOVAL (Specify)	27b. DATE THEREO!		22c NAM	E OF CEMET	ERY O	R CREMATORY		22d. LOCAT	TION (City, I	town, o	r county)		{\$lote)	
Burney	4/17/	59	130	me A	5/	1. 6.	enn	1/1-0	reger	2	un		721	d	
23. FUNERAL DIRECTOR'S S	IGNATURE		ADDR	ESS			24a. REC'E	BY REGIST	RAR 24b		TRAR'S SIGI				
A 18 /2 1	11/1	7	1	7		3. /	DATEAP	R 1 7 '5		agents on	hur S. 4	8			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Rea, Dist. No 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. COUNTY o. STATE **b. COUNTY** MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) iente. d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION d. STREET ADDRESS . IS RESIDENCE ON A FARM? 090 Spr.ngfield Road YES NO 3. NAME OF DECEASED First DATE Middle (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HR 5. SEX 6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In years just birthday) 7. MARRIED TO NEVER MARRIED Days WIDOWED D DIVORCED [USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or Jorgian country) 12. CITIZEN OF WHAT COUNTRY? durying most of working life, even if retired) 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME IN U. S. ARMED FORCES? 17. INFORMANT 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c)." INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: HYPERTENSIVE CARDIOVASCULAR DISEASE IMMEDIATE CAUSE (6) DUE TO ARTERTOSCLEROTIC HEART DISEASE 20 yrs Conditions, if ony, which gove rise to immediate DUE TO couse (o), stoting the under-1 yr ADVANCED SENILE DETERIORATION lying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19 WAS AUTOPSY PERFORMED? YES NO TO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I) or Port II of item 18.1 20c TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, 20f. (City or lown) Day, Year 20d. INJURY OCCURRED (County) factory, street, office bldg., etc.) Hour o.m. While: Not while of work of work

(Slote)

21. I certify that I attended the deceased fram 1935 59___, and that death accurred all2:30A M, from the causes and an the date stated above.

26 April

ACTUAL SIGNATURE

Maryland

ADDRESS (Street, city or town, state) "Liberty Road at Eldersburg, Sykesville P.O.,

_____1959 ...that I last saw the deceased

PHYSICIAN'S NAME (Type) Wm. H. Lawson, Jr., M.D. 220 BURIAL CREMATION, 226 DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d LOCATION (City, town, or county)

(Stote)

23. FUNERAL DIRECTOR'S SIGNATURE

REMOVAL (Specify)

240. REC'D BY REGISTRAR DATE APR 2 9 '59

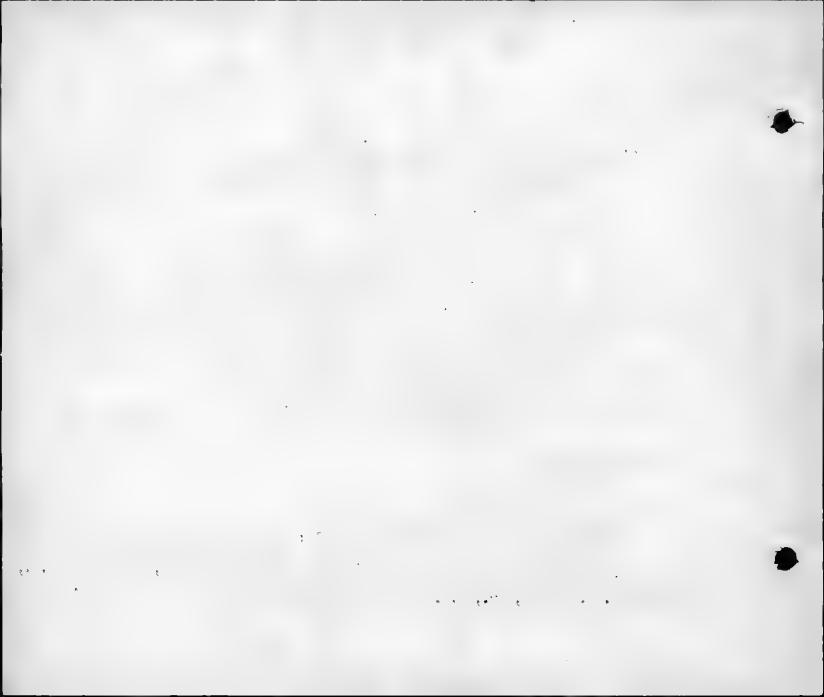
24b. REGISTRAR'S SIGNATURE arthur S. Kraus

15M 10/57

3 should

pup

VS A15 (4)



(State)

		Z.)	212	CER	TIFIC	ATE	OF DEAT	Н		Reg. D	lst. No.	U54	191			
1. 1	LACE OF DEATH							here decease	d lived. If institution	ni Reside	nce befo	re admiss	ion)			
	Carroll			M	MARYLAND		Maryland		b. COUNTY	Baltimore						
	. CITY OR TOWN (I	autside corporate limi	ts, write	c LENGTH OF S	TAY IN 16	С		JRAL and	AL and give nearest town)							
	(Rural) S	vkesville		Jyr. 8d	avs.		Garrison		^	43						
	NAME OF HOSPIT	AL (If not in hospital, g	ive street	oddress)	CL_(D_0	d	STREET ADDRESS			•	. IS RESIDENCE					
	OR INSTITUTION Springfie	1d State H	oeni t	- 7			none						NO T			
3.	NAME OF	Fir			ddle		Lou	4. DATE	Meni				Yeor			
	DECEASED (Type or print)	Samuel		Stna	rt	,	Wantz	OF DEATH			9 19 5					
5. 5	EX	6 COLOR OR RACE	7. MARR	IED NEVER MA			OF BIRTH		9. AGE (In years		FUNDER TYEAR IF UNDER 2					
	Male	White	WIDOWE		RCED [11	-22-68		last birthdoy) 90 yrs.	Months	Doys	Hours	Min.			
100	USUAL OCCUPATIO	N (Give kind of work	done 10b.	KIND OF BUSINES	S OR INDE			ar foreign (country)	12. CI	TIZEN C	OF WHAT	COUNTRY			
	Carpenter	ing`life, even if retired;	, [Unknown			Illinois			U.S.A						
13.	FATHER'S NAME					14 /	AOTHER'S MAIDEN	NAME								
	Elias Wa	ntz					Charlot	te Rir	neman							
		IN U. S. ARMED FOR		SOCIAL SECURITY	NO. 17.	INFORM	ANT		Addr	e 11						
	Unknown	Il yes, give wor or dores of a Unknown		nknown	R	ecor	ds Spring	field	State Hos	pita	1					
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]									INT	ERVAL BE					
	PART I. DEATH WAS CAUSED BY: Pneumonia										D days					
	1777 X DUE 10															
	Conditions, if or	y, which) {b	Due	to Cache	xia											
	gove rise to in cause (a), stating t	nmediate (-													
	lying couse last.		Caro	cinomia o	f pro	stat	9									
20	Charge 11. OTH	ER SIGNIFICANT CON	DITIONS C	ONTR BUTING TO	DEATH BU	NOT RE	LATED TO THE TERM	INAL DISEA	E CONDITION GIV	EN IN PAI	RT 1(o) 1	9. WAS	AUTOPSY			
CAT	PART II. OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY Chronic brain Syndrome associated with circulatory disturbance, with cere—PERFORMED?															
CERTIFICATION	Dral anterios of anosis with psychotic reaction 200. ACCIDENT WAS UNDERLYING D 200. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.) OR CONTRIBUTING D CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
MEDICAL	20c TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED Hour a. m. While Not while of work of work of work of work									(State)						
MED																
	21. I certify the	at I ottended the	decease	d framAp	ril	-1	19_58 to_A	pril-9	1959_	,that I	last so	sw the	deceased			
	alive an_Apr	jl-9	125	9, and the	hat deatl	h accui	rred at_9:00		m the couses a		the da					
	ACTUAL E	latter	Ku	(A) DA	1		C		treet, city or town,				ATE SIGNED			
	SIGNATURE	vacos	100		4	_M.D	opring1	iera s	tate Hosp	pital		4-	9-59			
	PHYSICIAN'S WO	lter Knopp	. M.I		/		Sykesyi	110.1	larvland							

TO FUNERAL DISCORNA After this certificate has been signed by the attending physician and completely filled in by Juneral director, page 3 shauld be detached for use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 shauld be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

er death. Page 4

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of

BURIAL CREMATION, 276. DATE THEREOF

23. FUNERAL DIRECTOR'S SIGNATURE

22c. NAME OF CEMETERY OF CREMATORY

ADDRESS

24b. REGISTRAR'S SIGNATURE
Colling S. Kraus DATE DAY REGISTRAR

VS A15 (4) 15M 9/55

TO HOSPITAL OR

Those call; Newell late in filing this - 5/14/54- ms.

requires that the

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

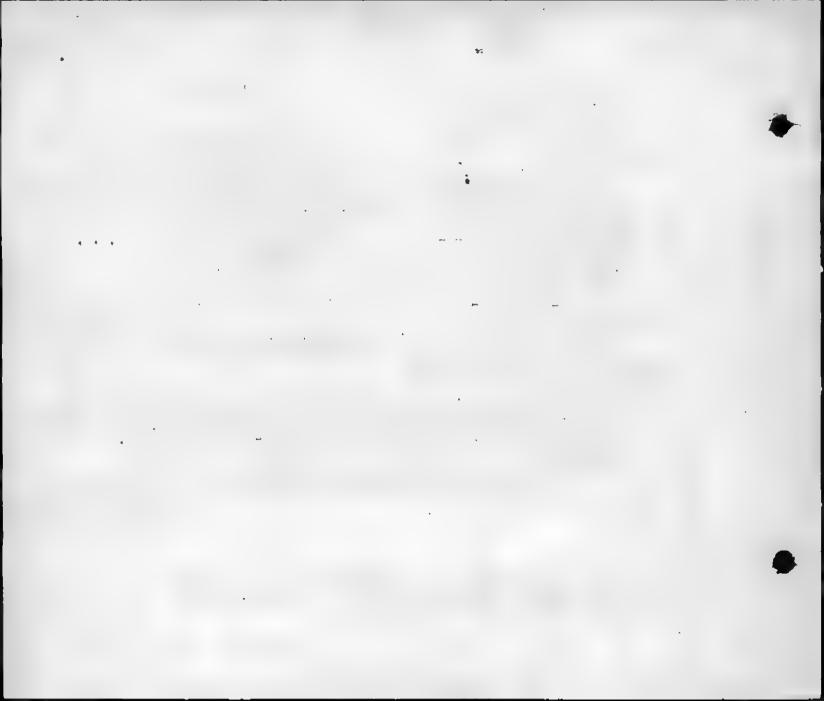


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH c. LENGTH OF STAY IN 16

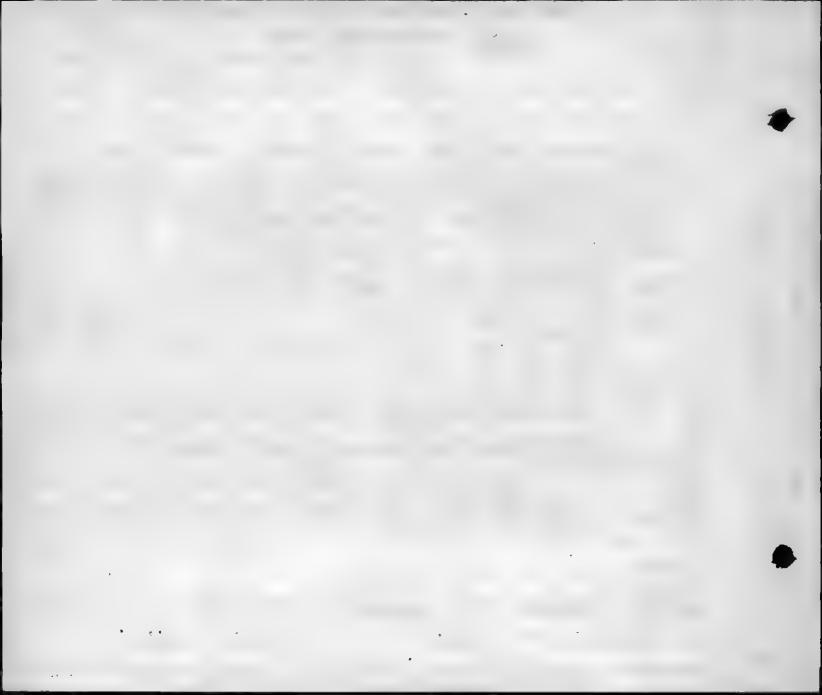
04203

Rea. Dist. No. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. COUNTY b. COUNTY Carroll Marvland Baltimore CITY OR TOWN (If autside carporate limits, write c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest tawn) RURAL and give nearest lawn) Sykesville (Rural) 2 Yrs..2 Dys Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? 1200 Valley Street Springfield State Hospital YES NOT NAME OF 4. DATE OF DEATH Middle Yeor (Type or print) Annie Wells Cheseltine 19 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH Months Days Female WIDOWED | DIVORCED | March 31 100. USUAL OCCUPATION [Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Housekeeper Maryland U.S.A. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Ernest Wells Mary Hammett 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 116. SOCIAL SECURITY NO. Address Springfield Hospital Record Nο 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I, DEATH WAS CAUSED BY: IMMEDIATE CAUSE (6) Arteriosclerotic cardiovascular disease Months 422.1 Canditions, if any, which) Bronchopneumonia Days gove rise to immediate **DUE TO** cause (a), slating the under-Generalized arteriosclerosis lying couse fost. Years Chronic brain syndrome associated with circulatory disturgance, with references CATION cerebral arteriosclerosis, with psychotic reaction. - Latent symbilis YES NO [20g. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (County) (State) foctory, street, office bldg., etc.) Haur a.m. Not while of work of work 195 I that I last saw the deceased 21. I certify that I attended the deceased from ___, and that deoth occurred at 12, 15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Springfield State Hospital PHYSICIAN'S Sykesyille, Maryland NAME (Type) 220 BUR AL CREMATION. 220 NAME OF CEMETERY OR CREMATORY 22d LOCATION |City lowerres county REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE APR 9 '59 24b. REGISTRAR'S SIGNATURE

0 <u>=</u> Filled ottending څ e has been signed by burial-tronsit permit. e RAL DIS



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



TO HOSPITAL OR

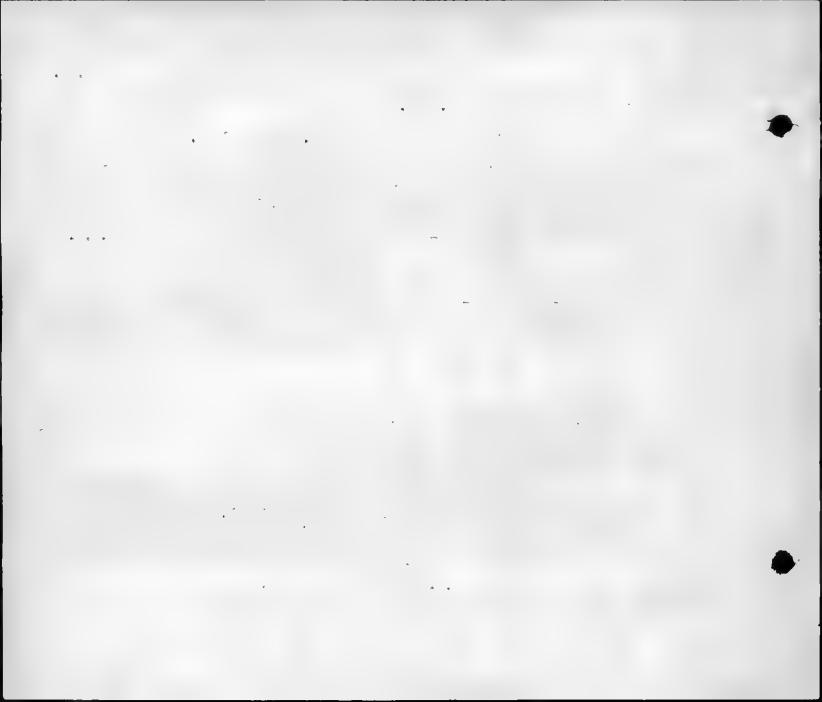
VS A15 (4) 15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4216 **CERTIFICATE OF DEATH** 04205

Reg. Dist. No.

		rroll	2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) o. STATE Maryland b. COUNTY Balto. Co.									
	b. CITY OR TOWN (IF RURAL and give new Sykesvill	15yrs. 2mos						here by				
1986	OR INSTITUTION	AL (If not in hospilot, give stre 1d State Hosp:	d STREET ADDRESS Balto.Cou	mty Pol:	ice. 🔿	· ×	ON	ESIDENCE A FARM? NO []				
	3. NAME OF DECEASED (Type or print)	Frank	Middle Lin		WILLIAMS	4. DATE OF DEATH	April	h	21,	Yeor 19 ⁵⁹		
	s. sex Male	6. COLOR OR RACE 7. MA	RRIED NEVER MARRIED		B. DATE OF BIRTH February 23		AGE (In years lost birthday)		YEAR IF UN			
	10a. USUAŁ OCCUPATIO during most of works NONE	N (Give kind of work done 10 ng life, even if retired)	INDUS	USTRY 11 BIRTHPLACE (Stote or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY U.S.A.								
	13. FATHER'S NAME				14 MOTHER'S MAIDEN	NAME						
1	Unknown	hun a south concession		T	Unknown							
	15. WAS DECEASED EVER IN U S ARMED FORCES? 16. SOCIAL SECURITY NO 17 uniform) (If yet, no or uniform) (If yet, give wor or dotte of service) - Springfield Hospital Records:											
		18. CAUSE OF DEATH [Enter only one couse per line for (o). (b). and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ONSET AND DEATH Months OUE TO										
Conditions, if ony, which gove rise to immediate couse (a), stating the <u>under-lying cause last.</u> DUE TO Iying cause last.												
^	PART II. OTH Mental 200 ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY)	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19. WAS AUTOPSY PERFORMED? YES NOTE:										
	ZOC TIME OF INJURY Hour o.m. p. m.	20c TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED Hour o. m. 19 Of work										
	21. I certify the	21. I certify that I attended the deceased from March 7, 105 to April 21, 1959, that I last saw the deceased alive on April 21, 1959, and that death accurred at 2:45P M, from the causes and an the date stated above.										
	ACTUAL SIGNATURE	justini de	l'Camp	1	Springfie	ADDRESS (Street	l, city or lown, s	tote)		DATE SIGNED		
1	PHYSICIAN'S NAME (Type)	Agustin delĈa	mpo, M.D.		Sykesvil	le, Mary	land			***		
	270 BURIAL CREMATION REMOVAL Specify)	4122159	S/ CAM	1/1/	nelow Box	298. LOCATION	City town, or	r county)	Mol	ote)		
	23_ FUNERAL DIRECTOR'S	SIGNATURE CHAPLE	1 Sold Said		25/1/	PR 2 3 '59		TRAR'S SIGN				
	/	1 / //			/	11 - V - V - V		** J. J. 7				



death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** Rea. Dist. No 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) · COUNTY Carroll **b.** COUNTY MARYLAND Marvland CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) Sykesville 2mos 28days Baltimore 21 d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS 26 Avenal Road Springfield State Hospital NAME OF Middle Month Minnie Margaret Neumeister Worteck April (Type or print) DEATH 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 9. AGE (In years IF JNDER I YEAR IF UNDER 24 HRS 5. SEX Female June 10, 1893 Manths White DIVORCED WIDOWED [7] 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Housewife - clerk Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Neumeister Louise Knoblock 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT Address No 214-26-9901 Springfield Hospital Records 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) Bronchonneumonia DUE TO Canditions, if any, which gave rise to immediate DUE TO cause (a), stating the underfying couse lost. CATIO 4

While

Nat while

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? Psychotic depressive reaction. YES NO TO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Month, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) factory, street, office bldg., etc.)

04207

e. IS RESIDENCE ON A FARM?

YES NO TO

Balto. Gittw

Doys

12. CITIZEN OF WHAT COUNTRY?

INTERVAL BETWEEN ONSET AND DEATH

Days

U.S.A.

at work at wark April 27. 159 that I last saw the deceased January 21. I certify that I attended the deceased fram. 8:45AM, fram the causes and an the date stated above. glive on April 27 and that death accurred at ADDRESS (Street, city or town, state) DATE SIGNED

Springfield State Hospital ACTUAL SIGNATURE

PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland 220. BURIAL CREMATION. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LQCATION (City, town, or county) (State) REMOVAL (Specify) URIA

FUNERAL DIRECTOR'S SIGNATUR 24b. REGISTRAR'S SIGNATURE ADD ESS 24g, REC'D BY REGISTRAR DATE APR 2 9 159 arthur & Kraus

VS A15 (4) 15M 9/5B



FOR STATE HEALTH DEPT. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is negresory, please execute the centries, writing the word "pending" in pendit in Item, 18. Give Pages 1, 2, and 3 to the funeral tor. Page 4 should be for dead to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to any files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and the vent within 72 hours after death.

I

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 19 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04208

	ZHLJ .			Reg. Dist. No.							
1	1. PLACE OF DEATH 6 COUNTY Carroll	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If o. STATE Maryland b. CC	institution. Residence before admission) DUNTY Carroll							
	b. CITY OR TOWN (If outs de cerporale fimits write #LRA- and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits,	write RURAL and give nearest town)							
	Rural Westminster R	made a se	X Rural Westminst	er R.F.D.6							
	d. NAME OF HOSPITAL OR INSTITUTION (IF not Smallwood, Md		J. STREET ADDRESS Smallwood	IS KES DONCE ON A FARMS YES NO							
	3. NAME OF DECEASED (Type or print) BERNAS	· F	WUEST DEATH CLA	Month Doy Year 9							
	Mole	ARRIED NEVER MARRIED 6. B.	Nov. 6, 1899 9. AGE In ya	Months Days Hours Min.							
	10c. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PCL ACCOUNTANT	Country Club	Baltimore, Md.	12 CITIZEN OF WHAT COUNTRY							
	13. FATHER'S NAME Adolph Wu	est	14. MOTHER'S MAIDEN NAME Thresa Flick								
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no. or unknown) (If yes, g ve war or doles of service)		FORMANT Ad Mrs. Edith Wuest R.	6 Westminster, Mc							
,	18. CAUSE OF DEATH [Enter only one couse per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	Sutto eater		INTERVAL BETWIEN							
	Conditions, if ony, which)	Housing									
	gave rise to immediate cause (a), stating the underlying DUE TO	gove rise to immediate cause (a), stating the underlying DUE TO									
)	16/	NS CONTRIBUTING TO DEATH BUT N	OT RELATED TO THE TERMINAL DISEASE CONDITION	GIVEN IN PART 1(0) 19, WAS AUTOPSY PERFORMED?							
	20a. EXTERNAL CAUSE WAS PRIMARY Nor CONTRIBUTING CAUSE OF DEATH. 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18) 1 aug was										
	B Hour a.m. 11 9 20	While Not while tacto	TE OF INJURY (Home, form, 201. (City or town) by, street, office/bldg., etc.)	(County) (State)							
	21. I certify that I taok charge of	the remains described about									
	apinian death resulted fram: Natu			determined manner							
	ACTUAL SIGNATURE COLUMN 2.										
all	EXAMINER'S JAMES T	MARSH	ASSISTANT MEDICAL EXAMINER C	4/9/59							
	220. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Society) BURIAL 4-11-59	22c. NAME OF CEMETERY OF EVERGREEN GE	crematory 22d. LOCATION (City, to Prinksbu								
	23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	· · · · · · · · · · · · · · · · · · ·	REGISTRAR'S SIGNATURE							
		Westminster, Mo	1. 100 4 4	en is die							

VS. A15ME 5M 2 457



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VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04900

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			2 43 4						Kañ nis	1. 140.		
1.	PLACE OF DEATH O. COUNTY Carroll		26	MARYLA	ND	2. USUAL RESIDENCE (STATE Maryland	Where decease	d lived. If institution b. COUNTY	n: Residenc	e befare	odmissi	on)
		autside carporate limit	s, write	c. LENGTH OF STAY IN	1Ь	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tawn)						
	(Rural) Sy	kesville		3yr.lmo.20	da	Baltimore 3 VO1, 4						
	d. NAME OF HOSPITA OR INSTITUTION	L (If not in haspital, gi	ve streat	address)		d. STREET ADDRESS e. IS RESIDENCE ON A FARM?						
		eld State I	losp:	Ltal		417 E. 2	8th. St					NO DE
3.	NAME OF DECEASED	Firs		Middle		Lost	4. DATE	Man	th	Day	Y	ear
	(Type or print)	Malster	-			Yeager	DEATH	4		2:	1	9 59
	SEX			RIED NEVER MARRIED	_ (DATE OF BIRTH		9. AGE (In years jost birthday)	IF UNDER		F UNDE Hours	R 24 HRS. Min.
	Male	White	WIDOW			11-6-97		61 yn.		,		
10c	 USUAL OCCUPATION during most of working 	N (Give kind of work d ng life, even if retired)	ane 10b.	SHIPPE FINE	NDU5	TRY 11. BIRTHPLACE (SIE	ale ar foreign c	ountry)	12. CITI	ZEN OF	TAHW	COUNTRY?
	Salesman		X	noismouse:		Maryla	nd		U.S	A.		
13.	FATHER'S NAME					14. MOTHER'S MAIDER	N NAME					
	John T. Ye					Ellie	(Ella	Miles)				
15. (Ye	WAS DECEASED EVER	IN U. S. ARMED FORCE		SOCIAL SECURITY NO.	17, IN	FORMANT		Add	e34			
	unknown	unknown		215-10-2428	Re	cords Sprin	gfield	State Hos	pital			
	18. CAUSE OF DEAT	H [Enter anily and cau	sa per li	ne far (o), (b), and (c).]							VAL BET	TWEEN
	PART I, DEATH WAS CAUSED BY									ONSET AND DEATH		
	3 3 2 X Due to											
	Conditions, if any, which) (h)											
	gave rise to im	mediate								-		
	cause (a), stating t											
7	lying couse last.	, (c)										
CATION				SHOCIATE C					SHITI			
Ξ.	meningoen	cephalitic	Will	th psychotic	TO	action.	in Part I as Day	t II of Stee 19 1	_		LES FE	NO 🗌
CERT	OR CONTRIBUTING	meningoencephalitic with psychotic reaction. 20a. ACCIDENT WAS UNDERLYING [] COR CONTRIBUTING [] COR CONTRIBUTING [] CONT										
		Manih, Doy, Yea	- 20-4 10	NJURY OCCURRED 20	- DI A	CE OF INJURY (Home, fo	204 4071	4- 3				****
EDICAL	Haur o. m.	monn, boy, red	While	_ Not while		ary, street, office bldg.,		ar town)	(C	ounly)		(Stole)
×	p. m.	19	at war	k al work	-							
	21. I certify the	at I attended the	deceas	ed from 12-1-	195	5, 19, ta_1	27:21	1959	,that I le	ast sav	v the	deceased
	all By May	21-	_, 12 5	221 L. and that de	eath	accurred at 10:	50 M, from	n the causes a	nd an th	e date	state	d abave.
	/	1000	,	(i. Da			ADDRESS (S	treet, city or town,	store)			TE SIGNED
	ACTUAL SIGNATURE	Jackey	1	us III	1 1	Sprin	gfield	State Hos	pital	. 4-	-21-	59
				0007								
	PHYSICIAN'S W.	alter Knopp	, M.	.D. /		Sykes	ville,	Maryland	***			
220	BURIAL, CREMATION	4, 22b. DATE THEREO	F	22c. NAME OF CEMETE	RY OR	CREMATORY	22d. LOCA	TION (City, town, o	r county)		(State)
	Burial	11/25/59		London Pa	plc.	Com-	Balt	imore, M	1.			
23.	FUNERAL DIRECTOR'S	SIGNATURE		ADDRESS	17	24a. RE	EC'D BY REGIST		TRAR'S SIG			
-	Mu. y.	Menu	is	Vsous-	RB	LICO / DATE	PR 2 2 '5	9 Cw	int 2. 1	Groves		
	V				V	Med.						
						V V - V 1						

4 × 4 8 1122 122 Carlot of the second of the se A CONTRACT OF SCHOOL SERVICE AND ADDRESS.

TO DEPUTY MEDICAL EXAMINER: This zerificate should be secuted within \$14 hours after death. If any delay is never execute the case, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral 4 should be it and 2 with form PM3. Page 5 may be related to FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Elle pages 1 and 2 with the State Baard or its designated agent, prior to burial, cremation, ar removal, and in any event within 72 hours ofter death.

VS. A15ME 5M 2/57

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04210

	4.1	1	Car	-
ea.	Dist	1. 1	Vo.	

	COUNTY	rroll	221	MARYLAND	a STATE	ESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland b. COUNTY Frederick					
ь	CITY OR TOWN HE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
	Sykasyilla 9 m 28 days				Burkittsville. Md. 10x-2						
-	d. NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give street address)				d. STREET ADDRESS		Tax 9	101	e. IS RESIDENCE		
	Springfield State Hospital				ON A FARM? YES NO						
3, 1	HAME OF DECEASED	Fir	11	Middle	Losi	4. DATE OF	Month	De	gy Yeor		
(Type or print)	Georg	ne .	Franklin	Zecker	DEATH	4	25	19 59		
5. S	EX			NEVER MARRIED B	DATE OF BIRTH		9. AGE (In years	IF UNDER TYEA	AR IF UNDER 24 HRS		
	M	W	WIDOWED		7-30-82		76 yrs.	Months Days	Hours Min.		
100	USUAL OCCUPATIO	N (Give kind of work a life, even if retired)	done 10b. KIN	D OF BUSINESS OR INDUST	RY 11. BIRTHPLACE (Ste	ole or foreign o	country)		OF WHAT COUNTRY?		
	farme		4	larm	Maryla	nd		U.S.	.A.		
13.	FATHER'S NAME		1)		14. MOTHER'S MAIDEN	NAME		1			
	Dawson D.	Zecher			Amanda D	utrow					
15.	WAS DECEASED EVE	R IN U. S. ARMED FO			FORMANT		Address		Control of the Contro		
Tat	no, or enknown)	It yes, give wor or dates of	del	9-36-2511 S	.S. Hospital	Record	is				
	The state of the s	H [Enter only one co						IIN	TERVAL BETWEEN		
	18. CAUSE OF DEATH (Enter only one course per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: 12 20 10 (1) 20 10 10 10 10 10 10 10 10 10 10 10 10 10								ONSET, AND DEATH		
	IMMEDIATE CAUSE (a) DICTION CONTROL CO										
1	THIT N DUE TO										
	Conditions, if an	100									
	(o), stoling the u										
	cause fast.	(c)								
CATION	G.B.G. B.G. B.G. B.G. B.G. B.G. B.G. B.										
CERTIF	120g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW IN HIS Y OF CURRED (Enter noture of injury in Port to Port II of Item 184										
MEDICAL	20c. TIME OF INJURY Month, Day, Year Hour a. m. 4 19 White Not white of work o										
	21. I certify that I took charge of the remains described above, held an Autapsy . Inspection . Inquiry . and in my										
	apinion death	resulted fram:	Natural ca	uses . Accident [, Suicide,	Homicide	. Undete	rmined man			
	ACTUAL SIGNATURE	we I.	The	reh	_M.D. CHIEF MEDICAL	EXAMINER [l		DATE SIGNED		
	EXAMINER'S NAME (TYPE)	AMES 1	1/	MARSH	DEPUTY MEDICA				4/25/59		
220	BURIAL CREMATION	1. 226. DATE THEREO	5-9 2	CO. NAME OF CEMETERY OR	CREMATORY	13	TION (City, lown,	S V I	(Stole)		
23.	FUNERAL DIRECTOR	SIGNATURE	100	ADDRESS	240. RE	C' DY REGIS	IRAR 246. REGIS	STRAR'S SIGNAT	TURE		
()	albeli	11 00	Med	gletow.	DATE	APR 29	'59 a	rthun & H	Tour		

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